Supreme Court, U.S.
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No. OFFICE OF THE CLERK

In The

Supreme Court of the United States

October Term, 1995

BRIDGET ANN HAAS, by and through her father and legal guardian, William E. Haas,

Petitioners,

vs.

RICKY WYATT and CHARLES FETNER (as acting Commissioner of Mental Health for the State of Alabama), et al.,

Respondents.

Petition For Writ Of Certiorari To The United States Court Of Appeals For The Eleventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED FOR REVIEW

The State of Alabama operates Bryce Hospital to care for mentally ill persons. In 1970, several Bryce employees and guardians of Bryce residents commenced this action in the United States District Court for the Middle District of Alabama. The plaintiffs named various state officials as defendants and prayed for a decree prohibiting the discharge of employees and the reduction of medical services at Bryce. Plaintiffs sought this relief on behalf of the class of persons similarly situated to them.

The State also operates William D. Partlow Developmental Center, formerly known as Partlow State School. Partlow is a relatively large, congregate care facility for retarded persons. The plaintiffs amended their complaint to name the superintendent of Partlow as a defendant. The district court construed this amendment as enlarging the class to include residents of Partlow, as well as residents and employees of Bryce.

Bridget Ann Haas is a profoundly retarded woman who has resided at Partlow since 1990, and Col. William E. Haas (U.S. Army, ret'd) is her father and legal guardian. In 1994, Ms. Haas, acting through her father and guardian, moved for leave to intervene in the action. She alleged that the plaintiffs sought to require the State to move residents out of large facilities such as Partlow and into smaller, community based facilities. She further alleged this relief ran contrary to her interests.

When Ms. Haas moved for leave to intervene, the class representatives had never included any Partlow

QUESTIONS PRESENTED FOR REVIEW – Continued

resident or other retarded person. At that time, the court had not even formally certified the class. None of the named representatives were still active in the litigation. The class had moved the district court to enter an order finding that the defendants had violated the Americans with Disabilities Act by segregating mentally retarded persons in large facilities, away from the general population.

The district court held that existing parties adequately protected Ms. Haas's interests in the litigation and denied leave to intervene. The United States Court of Appeals for the Eleventh Circuit affirmed, holding that the district court's finding was not clearly erroneous.

Ms. Haas respectfully petitions this Court to issue a writ of certiorari to review:

1. Whether the court of appeals erred by employing a clearly erroneous standard to review the decision of the district court.

2. Whether the court of appeals erred by failing to reverse the district courts decision denying intervention.

LIST OF ALL PARTIES TO THE PROCEEDING BELOW

Eric Boothe
Glenda Brandner
Wolfgang Brandner (as legal guardian of Glenda Brandner)
Tom Brassell, individually and in his capacity as Comptroller for the State of Alabama
Brent Bugsh
Kenneth Cook
Charles Fetner, as acting Commissioner of Mental Health
Michael Guins
Annie Laurie Gunter, individually and in her capacity as Treasurer for the State of Alabama
Bridget Ann Haas
William E. Haas (as guardian and next friend of Bridget Ann Haas)
Robert Hanna
Amelia B. Heath
William Holden, Jr.
Frankie Hopkins
Adelia Keebler
Diane Martin
Richard Mills
Joseph L. Moudry
Mary Beth Parker
D.A.R. Peyman, Jr.
Stephanie Ramsey
Mrs. W. C. Rawlins, Jr. (as guardian for Ricky Wyatt)
David S. Schoel
J. Fred Schoel (as father and legal guardian of David S. Schoel)
Kim Smelley
William Smith
Brenda N. Stacy

LIST OF ALL PARTIES TO THE PROCEEDING BELOW – Continued

Henry Steagall, individually and in his capacity as Director of Finance for the State of Alabama
Benjamin Stokes
Ken Wallis, as Receiver of the Mental Illness and Mental Retardation Operation
Gene Washington
Wayne Williams
Gregory Woelke
Ricky Wyatt

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Wyatt v. Stickney, 344 F. Supp. 387 (M.D. Ala. 1972).

Wyatt v. Aderholt, 368 F. Supp. 1382 (M.D. Ala. 1973).

Wyatt v. Aderholt, 368 F. Supp. 1383 (M.D. Ala. 1974).

Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974).

Wyatt v. Wallis, 1986 WL 29194 (M.D. Ala. 1986).

Wyatt, by and Through Rawlins v. King, 793 F. Supp. 1058 (M.D. Ala. 1992).

Wyatt by and Through Rawlins v. King, 803 F. Supp. 377 (M.D. Ala. 1992).

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Wyatt v. R. Emmett Poundstone, No. 3195-N (M.D. Ala. October 3, 1995) (order ruling on motion to recertify the class).

STATEMENT OF BASIS OF JURISDICTION IN THIS COURT

The court of appeals entered its unpublished order on January 31, 1996. Ms. Haas timely moved for rehearing or rehearing *en banc*. Under 11th Cir. R. 35-6, all requests for rehearing *en banc* are treated as requests for rehearing. On March 28, 1996, the court of appeals entered its order denying rehearing and denying rehearing *en banc*. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

Rule 24. Intervention

(a) Intervention of Right. Upon timely application anyone shall be permitted to intervene in an action: (1) when a statute of the United States confers an unconditional right to intervene; or (2) when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties.

(b) Permissive Intervention. Upon timely application anyone may be permitted to intervene in an action: (1) when a statute of the United States confers a conditional right to intervene; or (2) when an applicant's claim or defense and the main action have a question of law or fact in common. When a party to an action relies for ground of claim or defense upon any statute or executive order administered by a federal or state governmental

officer or agency or upon any regulation, order, requirement, or agreement issued or made pursuant to the statute or executive order, the officer or agency upon timely application may be pe: nitted to intervene in the action. In exercising its discretion the court shall consider whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties.

(c) Procedure. A person desiring to intervene shall serve a motion to intervene upon the parties as provided in Rule 5. The motion shall state the grounds therefor and shall be accompanied by a pleading setting forth the claim or defense for which intervention is sought. The same procedure shall be followed when a statute of the United States gives a right to intervene. When the constitutionality of an act of Congress affecting the public interest is drawn in question in any action in which the United States or an officer, agency, or employee thereof is not a party, the court shall notify the Attorney General of the United States as provided in Title 28, U.S.C. § 2403. When the constitutionality of any statute of a State affecting the public interest is drawn in question in any action in which that State or any agency, officer, or employee thereof is not a party, the court shall notify the attorney general of the State as provided in Title 28, U.S.C. § 2403. A party challenging the constitutionality of legislation should call the attention of the court to its consequential duty, but failure to do so is not a waiver of any constitutional right otherwise timely asserted.

STATEMENT

The State of Alabama operates Bryce Hospital to care for mentally ill citizens. R1-1-4. In 1970, several Bryce employees, along with several guardians of Bryce residents, sued the State and various other defendants. R1-1-2. The employees sought to represent a class of similarly situated employees, and the guardians and residents sought to represent a class of similarly situated guardians and residents. R1-1-2. One lawyer represented both groups of named plaintiffs and both putative classes. R1-1-7. The complaint prayed for a decree requiring defendants ". . . to insure and [to] direct that no present course of mental health treatment and services now being given to plaintiffs who are patients shall be in any way interrupted, changed, or interfered with." R1-1-7. The complaint also sought an injunction prohibiting the defendants from firing Bryce employees. *Id.*

Plaintiffs requested a preliminary injunction. R1-3-1. Mrs. W.C. Rawlins submitted an affidavit in support of the motion. R1-3-11. Mrs. Rawlins was the guardian for Ricky Wyatt, a mentally ill child who was also one of the named plaintiffs in the case. R1-3-11. In her affidavit, Mrs. Rawlins revealed that she was also a Bryce employee. R1-3-11. Under oath, she stated that Bryce provided Ricky with good care. R1-3-11. The district court later found that Bryce was a degrading, humiliating institution. *Wyatt v. Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971).

Plaintiffs amended their complaint to name the Superintendent of Partlow State School as a defendant. R1-13-1. The State operated Partlow to care for mentally

retarded citizens. *Wyatt v. Stickney*, 344 F. Supp. 387, 389 (M.D. Ala. 1972). Plaintiffs alleged that they or members of their putative class were in danger of being transferred to Partlow. R1-13-2.

According to the district court, when the plaintiffs added the superintendent of Partlow as a defendant, *they expanded their class to include residents of Partlow as members of the class they sought to represent. Wyatt v. Stickney*, 344 F. Supp. at 389. Thus, mentally ill residents of Bryce ostensibly came to represent mentally retarded residents of Partlow. Nonetheless, the district court did not enter an order formally certifying a class.

For reasons not entirely clear from the record, the case began to focus on the care that defendants provided to mentally ill and mentally retarded individuals, rather than on how the defendants treated Bryce employees. *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974) (noting shift in focus of litigation). As noted above, the district court found that Bryce was inhumane. *Wyatt v. Stickney*, 334 F. Supp. at 1343. The court also found that Partlow was grotesquely inadequate. *Wyatt v. Stickney*, 344 F. Supp. at 391. To remedy these shortcomings, the court adopted two sets of standards designed to ensure adequate care. *Wyatt v. Stickney*, 344 F. Supp. at 379 (adopting Bryce standards); *Wyatt v. Stickney*, 344 F. Supp. at 395 (adopting Partlow standards). Eventually known as the *Wyatt* standards, one set applied to Bryce and the other applied to Partlow. The court enjoined the defendants from failing to comply with the *Wyatt* standards. *Id.*

Plaintiffs and defendants began litigating whether defendants had complied with the *Wyatt* standards. *Wyatt*

by and Through Rawlins v. King, 811 F. Supp. 1533, 1535 (M.D. Ala. 1993) (discussing history of litigation over *Wyatt* standards). Eventually, plaintiffs began ". . . to expand the focus of the litigation to the provision of community placements." *Compare Wyatt by and Through Rawlins v. King*, 803 F. Supp. 377, 385 (M.D. Ala. 1992), *with Wyatt v. Aderholt*, 503 F.2d 1305, 1317 (5th Cir. 1974) (noting that plaintiffs previously sought ". . . only to ensure that conditions in the state institutions will be such that patients confined there will have a chance to receive adequate treatment"). In 1986, the court approved a consent decree purporting to end that round of the litigation. R6-1101-1. The decree required the defendants to make reasonable progress in placing mentally ill citizens and mentally retarded citizens into facilities based in the community. R6-1101-3.

In 1991, defendants moved the district court to enter an order finding that they had complied with the 1986 decree and terminating this litigation. R6-1167-1. In 1993, plaintiffs requested the district court to find that defendants had violated the 1986 decree. R6-1564-1. Plaintiffs also alleged that defendants violated the Americans with Disabilities Act by segregating mentally ill citizens and mentally retarded citizens from the rest of the general population. R6-1563-1.

In the midst of the latest round of litigation, Bridget Haas moved for leave to intervene in this action. R11-131-1. Ms. Haas made this motion by and through her father and legal guardian, William E. Haas. *Id.* Ms. Haas is a profoundly retarded adult who resides at Partlow. *Id.* She alleged that she could not receive adequate care at a community based facility, and that she needed to

remain at Partlow. R11-131-13. She further alleged that Partlow should be required to continue to improve its care.

The district court denied Ms. Haas's motion to intervene. R16-611-1. The district court concluded that existing parties adequately protected Ms. Haas's interests. *Id.* The United States Court of Appeals for the Eleventh Circuit held that the district court's conclusion was not "clearly erroneous." Because the court of appeals believes that it lacks jurisdiction over appeals from decisions correctly denying leave to intervene, the court dismissed the appeal.

Ms. Haas applied for rehearing or, in the alternative, rehearing *en banc*. She argued that the court of appeals had erred by employing a clearly erroneous standard to review the decision of the district court. She also argued that the court erred by failing to reverse the decision of the district court. The court denied her application for rehearing.

When the court of appeals heard oral argument in this matter, the court also heard argument on two other matters arising from the *Wyatt* litigation. In one matter, the defendants sought to appeal from an order certifying the class, which order was entered after Ms. Haas was denied leave to intervene. In the other matter, the defendants sought a writ of mandamus requiring United States District Court Judge Myron Thompson to recuse himself. As yet, the court of appeals has not entered decisions in this matter.

ARGUMENT FOR ALLOWANCE OF THE WRIT

A. On the question of whether to apply an abuse of discretion or a *de novo* standard of review to appeals from orders denying intervention as of right, the decisions of the courts of appeals are in conflict.

To intervene as a matter of right under Fed. R. Civ. Pro. 24(a), a movant must show 1) that her motion to intervene was timely, 2) that she claims an interest relating to the transaction which is the subject of the action, 3) that her situation is such that the disposition of the action may impair her ability to protect her interest, and 4) that existing parties may be inadequate to protect her interest. *Chiles v. Thornburgh*, 865 F.2d 1197, 1213 (11th Cir. 1989). Although they apply an abuse of discretion standard to determine whether a motion to intervene is timely, several courts of appeal have applied a *de novo* standard of review to determine whether district courts have erred by finding that defendants have failed to meet the other requirements for intervention under Rule 24(a). *B.H. v. McDonald*, 49 F.3d 294 (7th Cir. 1995); *Alameda Water & Sanitation Dist. v. Browner*, 9 F.3d 88 (10th Cir. 1993); *Sierra Club v. Robertson*, 960 F.2d 83 (8th Cir. 1992); *United States v. Texas Eastern Transmission Corp.*, 923 F.2d 410 (5th Cir. 1991); *Grubbs v. Norris*, 870 F.2d 343 (6th Cir. 1989). Other courts of appeal have employed an abuse of discretion standard to review such decisions. *In re Sierra Club*, 945 F.2d 776 (4th Cir. 1991); *International Paper v. Town of Jay, Me.*, 887 F.2d 338 (1st Cir. 1989); *Harris v. Pernsley*, 820 F.2d 592 (3d Cir. 1987); *California v. Tahoe Regional Planning Agency*, 792 F.2d 779 (9th Cir. 1986); *United States v. Hooker Chems. & Plastics*, 749 F.2d 968 (2d Cir. 1984).

Prior to this case, it appeared that the United States Court of Appeals for the Eleventh Circuit employed a *de novo* standard of review to determine whether a district court erroneously denied a motion to intervene as of right, except when the district court had held that the motion was untimely. *See, e.g., Federal Sav. & Loan Ins. Corp. v. Falls Chase Special Taxing Dist.*, 983 F.2d 211 (11th Cir. 1993). However, in this case, the court of appeals reasoned that the district court had found, as a factual matter, that existing parties adequately protect Ms. Haas's interests. Because the court of appeals could not say that this supposed factual finding was "clearly erroneous," the court refused to reverse the denial of intervention. We submit there is little, if any, distinction between the clearly erroneous standard and the abuse of discretion standard. *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. 384, 401 (1990); Childress, *Federal Standards of Review* (2nd Ed) § 4.21. Thus, in this case, the court of appeals rendered a decision in accordance with those opinions employing an abuse of discretion standard to review denials of motions to intervene.

In its *per curiam* opinion, the court of appeals did not explain why it employed a clearly erroneous standard in this case, even though the court had previously employed a *de novo* standard in other cases. However, we note that the Honorable Levin H. Campbell, Senior U.S. Circuit Judge for the First Circuit, sat by designation on the panel deciding this case. We further note that then Chief Judge Campbell wrote the opinion for the court in *International Paper v. Town of Jay, Me.*, 887 F.2d 338 (1st Cir. 1989). In *International Paper*, 887 F.2d at 344, the first

circuit adopted the abuse of discretion standard to review orders denying leave to intervene.

We submit that the question of adequate representation is a legal question, notwithstanding the view of the court of appeals in this case. Even when one considers the opinions of the courts which employ an abuse of discretion standard, it seems clear that the question of whether intervention should be allowed as a matter of right is a legal question, not a factual one. In *In re Sierra Club*, 945 F.2d at 780, the court of appeals held that the district court committed an abuse of discretion by finding that the South Carolina Department of Health and Environmental Control adequately represented the Sierra Club in an action involving hazardous waste permits, because the Department was charged with representing the interests of the entire State, while the Sierra Club only represented the interests of environmentalists. In *Harris v. Pernsley*, 820 F.2d at 601, the court held that the district court committed no abuse of discretion by finding that a judicial decree would fail to implicate the legal duties of a district attorney, if the decree required a jail to discharge prisoners.

Regardless of whether *In Re Sierra Club* and *Harris v. Pernsley* were correctly decided, the issues before those courts were legal. Absent some evidence of collusion, the question of whether a State represents the interests of all of its citizens or only a few does not turn on the interpretation of physical evidence or whether witnesses tell the truth. The question of whether discharging prisoners will affect the legal duties of a district attorney would not likely involve a decision on whether one piece of evidence was more probative than another.

Although the court of appeals apparently viewed the finding of adequate representation in this matter as a finding of fact, the district court did not purport to base its decision on the weight of the evidence or any other matter typically associated with a factual finding. Thus, the district court did not purport to decide that Ms. Haas really does not live at Partlow or that she would really be better off residing somewhere else. Instead, the district court held Ms. Haas was adequately represented by the existing parties, because the court found that she failed to raise any issues except those raised by the parties. We presume the district court reached this decision by referring to the pleadings, motions, and briefs in the record.

As a general rule, appellate courts review legal questions *de novo*. The decision to apply this standard is an important one. This Court has characterized *de novo* review as quite searching and intrusive, justifying review of the entire record. *Pierce v. Underwood*, 487 U.S. 552, 560 (1988); *Anderson v. Bessemer City*, 470 U.S. 564, 574-75 (1985). The phrase "*de novo*" implies that the reviewing court will look at the question anew and will decide the case according to its own views, rather than deferring to the views of the district court.

In contrast, under an abuse of discretion standard or a clearly erroneous standard, the court of appeals must defer to the findings of the district court. *Cooter & Gell v. Hartmarx Corp.*, 496 U.S. at 404, 405 (1990). In *United States v. U.S. Gypsum Co.*, 333 U.S. 364, 395 (1948), the Court wrote: "A finding is 'clearly erroneous' when although there is evidence to support it, the reviewing court on the entire evidence is left with the definite and firm conviction that a mistake has been committed."

Although the distinction between the *de novo* standard and the abuse of discretion standard is impossible to quantify, the choice of which standard to apply can determine the outcome of an appeal. *Salve Regina College v. Russell*, 499 U.S. 225, 239 (1991). In a tax case, the court below has very clearly stated its own views on this subject:

> Quite frankly, we would have affirmed the district court had it reached a different result, and if we were reviewing this matter *de novo*, we may well have decided it differently. By definition, however, under the abuse of discretion standard of review there will be occasions in which we affirm the district court even though we would have gone the other way had it been our call. That is how an abuse of discretion standard differs from a *de novo* standard of review. As we have stated previously, the abuse of discretion standard allows "a range of choice for the district court, so long as that choice does not constitute a clear error of judgment." *United States v. Kelly*, 888 F.2d 732, 745 (11th Cir. 1989) (citing *Kern v. TXO Prod. Corp.*, 738 F.2d 968, 970-71 (8th Cir. 1984) ("The very concept of discretion presupposes a zone of choice within which the trial courts may go either way."). We believe the district court's decision was within its range of choice, although perhaps not by a wide margin, and that no clear error of judgment has been demonstrated. Therefore, we AFFIRM.

In re Rasbury, 24 F.3d 159, 168-169 (11th Cir. 1994).

In this case, the district court decided that existing parties adequately protected Ms. Haas's interests in this

litigation, even though, among other things, 1) she ostensibly belonged to a class which had never been certified, 2) the original class representatives had ceased being active in the litigation, and 3) the "class," such as it was, sought relief that she opposed. Had the court of appeals felt itself free (or obligated) to review the question before it under a *de novo* standard, the court may well have hesitated to reach the same conclusion that the district court reached.

In summary, we petition the Court to decide whether courts of appeal should use a *de novo* standard to review district court decisions denying intervention as of right, except when the district denies an application for intervention on grounds of timeliness. With regard to this issue, the decisions of the courts of appeal are evenly split. In any given case involving intervention as of right, this issue could be important, because its answer could determine the outcome of an appeal. In this particular case, the issue is unusually important, because the court of appeals (or, indeed, this Court) may well have decided to reverse the district court's decision, if the court had made its own judgment about the propriety of intervention.

B. The court of appeals sanctioned a substantial departure from the accepted and usual course of judicial proceedings.

Ms. Haas ostensibly belongs to the plaintiff class in this action. That class moved the court to enter an order finding the defendants have violated the Americans with Disabilities Act by segregating mentally retarded persons

from the rest of the population. In particular, the class urges the district court to require defendants to care for mentally retarded persons in community facilities, rather than in large congregate care facilities such as Partlow. Ms. Haas's guardian firmly believes that Ms. Haas needs the type of care afforded in congregate care facilities and that her needs would not be met in a community care facility.

Despite the clear conflict between the goals of the class and Ms. Haas, the district court held that existing parties adequately represent Ms. Haas's interests. The court of appeals affirmed that holding as not "clearly erroneous." In doing so, the court of appeals sanctioned a departure from the usual and accepted course of judicial proceedings, so that the exercise of this Court's supervisory power is necessary.

The extent of this departure can be appreciated when viewed in light of the condition of this action when Ms. Haas moved for leave to intervene. At that time, the action had been pending for nearly 25 years. Notwithstanding Fed. R. Civ. Pro. 23(c)(1), the district court had yet to enter an order formally certifying the class. The original named representatives of the class were no longer active in the action. The named representatives had never included a profoundly retarded person, much less a resident of Partlow. The district court thus denied Ms. Haas the opportunity to intervene, even though her interests were adverse to the headless, formless class to which she allegedly belonged.

The court of appeals appeared to go out of its way to sanction this state of affairs. After the district court

denied Ms. Haas's motion to intervene, the district court entered an order certifying the class and allowing other persons, including a mentally retarded man, to intervene as named representatives. Yet the court of appeals expressly based its holding on the state of the record when the district court denied Ms. Haas's motion. *Wyatt v. Hanan*, No. 95-6013, p.4 n.2 (11th Cir. 1996) (stating, "Our holding today is based on the state of the record before the district court at the moment it denied Haas leave to intervene.").

The district court implied that the defendants adequately protected Ms. Haas's interests. However, it should be noted that nothing in the law charges the defendants with the responsibility of protecting Ms. Haas's interests. The defendants presumably have an extraordinary number of interests in this action, which has consumed over a quarter of a century and which has involved practically, if not literally, every aspect of defendants' actions regarding mentally ill and mentally retarded persons in the defendants' custody. Assuming that they are willing to undertake an obligation that they are unobligated to bear, and further assuming that they are willing to elevate Ms. Haas's interests to a status equal to or greater than their own, one must bear in mind the early history of this litigation, in which the district court found that the defendants treated mentally retarded persons in an unimaginably terrible fashion. Although defendants have improved their conduct, the district court still holds a very dim view of them. They are in no event adequate to protect Ms. Haas's interests.

In *Trbovich v. United Mine Workers*, 404 U.S. 528, 539 n.5 (1972), this Court observed that a person should be

allowed to intervene if existing parties "may be" inadequate to represent that person's interests. The Court further observed that a person seeking intervention need only make a minimal showing to demonstrate the possible inadequacy of representation. *Id.* The Advisory Committee Notes on the 1966 Amendment to Fed. R. Civ. Pro. 24 state that a person should be allowed to intervene in a class action, if the person is a member of the class and if the class representative inadequately represents him. In refusing to reverse the decision of the district court, the court of appeals sanctioned a substantial departure from these principles. Only an exercise of this Court's supervisory power can remedy that departure.

In summary, we ask this Court to decide whether the district court erred by denying intervention, regardless of whether the district court's decision is reviewed for legal error or for abuse of discretion.

Respectfully submitted,

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IN THE UNITED STATES COURT OF APPEALS

FOR THE ELEVENTH CIRCUIT

No. 95-6013

D. C. Docket No. CV-70-T-3195-N

RICKY WYATT, by and through his Aunt and Legal Guardian, Mrs. W. C. Rawlins, Jr., GLENDA BRANDNER, by and through her husband and legal guardian, Wolfgang Brandner; DAVIS S. SCHOEL, by and through his father and legal guardian, J. FRED SCHOEL, Dr., D. A. R. PEYMAN, JR., JOSEPH L. MOUDRY, BRENDA N. STACEY, WILLIAM HOLDEN, JR., AMELIA B. HEATH, for themselves and all others similarly situated,

Plaintiffs,

DIANE MARTIN, MARY BETH PARKER, WILLIAM SMITH, ADELIA KEEBLER, MICHAEL GUINS, RICHARD MILLS, KIM SMELLEY, FRANKIE HOPKINS, KENNETH COOK, WAYNE WILLIAMS,

Intervenors,

WILLIAM HAAS, as Guardian and next friend of BRIDGET ANN HAAS,

Movant-Appellant,

versus

RICHARD E. HANAN, as Commissioner of Mental Health and the State of Alabama Mental Health Officer; HENRY STEAGALL, individually and in his capacity as Director of Finance for the State of Alabama; TOM BRASSELL, individually and in his capacity as Comptroller of the State of Alabama; ANNIE LAURIE GUNTER, individually and in her capacity as Treasurer of the State

of Alabama; KEN WALLIS, as Receiver of the mental illness and mental retardation operation,

Defendants-Appellees,

UNITED STATES OF AMERICA,

Amicus.

Appeal from the United States District Court
for the Middle District of Alabama

(January 31, 1996)

Before TJOFLAT, Chief Judge, RONEY and CAMPBELL*, Senior Circuit Judges.

PER CURIAM:

William Haas, as guardian and next friend of Bridget Ann Haas, appeals the district court's denial of his motion to intervene in this long-standing class action concerning the conditions in Alabama's institutions for the mentally ill and the mentally retarded. *See* Fed.R.Civ.P. 24(a). We find no error in the court's refusal to allow Haas to intervene as a matter of right.[1] We therefore dismiss Haas' appeal for want of jurisdiction. *See Chiles v. Thornburgh*, 865 F.2d 1197, 1212 (11th Cir. 1989); *EEOC v. Eastern Airlines, Inc.*, 736 F.2d 635, 637

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*Honorable Levin H. Campbell, Senior U.S. Circuit Judge for the First Circuit, sitting by designation.

[1] Alternatively, Haas sought permissive intervention under Fed.R.Civ.P. 24(b). The district court denied that motion as well. Haas does not appeal this portion of the district court's ruling, and thus we deem the issue abandoned.

(11th Cir. 1984) ("If we find that the district court's disposition of the petition to intervene was correct, [or within its discretion,] then our jurisdiction evaporates because the proper denial of leave to intervene is not a final decision, and we must dismiss the[ ] appeal[ ] for want of jurisdiction.").

In 1972, the district court granted the plaintiffs injunctive relief that required the officials of the Alabama Department of Mental Health and Mental Retardation to bring their facilities into compliance with certain minimal federal constitutional standards. In 1986, the court approved a consent decree that resolved conflicts between the parties over the adequacy of the state's funding and administration of facilities under the court-ordered standards. Most recently, the district court has held hearings on the defendants' compliance (or noncompliance) with the decree and for further relief under the Americans with Disabilities Act of 1990.

Bridget Ann Haas, the daughter of William Haas, is a resident of the Partlow Development Center in Tuscaloosa, Alabama. She is thirty years old, but has the mental ability of an eighteen-month-old child. Haas asserts in his moving papers that Bridget is entitled "to continue to receive, at Partlow, care of the type currently provided by Partlow . . . subject to reasonable improvements as indicated by medical science." He contends that the class plaintiffs in this case are urging the court "to decrease the services offered at Partlow or to close Partlow." He has therefore asked the district court, after granting him intervention, to order the defendants to keep Partlow open and to continue to provide needed individual care to Bridget at that institution and, further,

to continue to improve Partlow's facilities and programs as long as Bridget resides there. In short, Haas wants the court to ensure that Partlow will not be closed and that his daughter will be allowed to remain there indefinitely.

We cannot say that the district court's finding of fact – that Haas' and his daughter's interests are being adequately protected – is clearly erroneous. Given that inadequacy of representation (of the putative intervenor's interest) is an indispensable element of a claim of intervention as a matter of right, *Chiles v. Thornburgh*, 865 F.2d 1197, 1213 (11th Cir. 1989), and that Haas' motion fails on that point, the district court's denial of intervention as of right must be affirmed and the appeal dismissed.[2]

APPEAL DISMISSED.

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[2] In affirming the district court's decision to deny intervention, we are mindful of the fact that Haas and his daughter have yet to suffer the untoward consequences they fear may result in due time. Accordingly, if in the future the plaintiffs are not adequately representing the Haas' interests, the Haases may once again seek leave to intervene in this case. Our holding today is based on the state of the record before the district court at the moment it denied Haas leave to intervene.

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 95-6013

RICKY WYATT, by and through his Aunt and Legal Guardian, Mrs. W. C. Rawlins, Jr., GLENDA BRANDNER, by and through her husband and legal guardian, Wolfgang Brandner; DAVIS S. SCHOEL, by and through his father and legal guardian, J. FRED SCHOEL, Dr., D. A. R. PEYMAN, JR., JOSEPH L. MOUDRY, BRENDA N. STACEY, WILLIAM HOLDEN, JR., AMELIA B. HEATH, for themselves and all others similarly situated,

Plaintiffs,

DIANE MARTIN, MARY BETH PARKER, WILLIAM SMITH, ADELIA KEEBLER, MICHAEL GUINS, RICHARD MILLS, KIM SMELLEY, FRANKIE HOPKINS, KENNETH COOK, WAYNE WILLIAMS,

Intervenors,

WILLIAM HAAS, as Guardian and next friend of BRIDGET ANN HAAS,

Movant-Appellant,

versus

RICHARD E. HANAN, as Commissioner of Mental Health and the State of Alabama Mental Health Officer; HENRY STEAGALL, individually and in his capacity as Director of Finance for the State of Alabama; TOM BRASSELL, individually and in his capacity as Comptroller of the State of Alabama; ANNIE LAURIE GUNTER, individually and in her capacity as Treasurer of the State

of Alabama; KEN WALLIS, as Receiver of the mental illness and mental retardation operation,

Defendants-Appellees,

UNITED STATES OF AMERICA,

Amicus.

Appeal from the United States District Court
for the Middle District of Alabama

Before TJOFLAT, Chief Judge, RONEY and CAMPBELL*, Senior Circuit Judges.

JUDGMENT

This cause came to be heard on the transcript of the record from the United States District Court for the Middle District of Alabama, and was argued by counsel;

UPON CONSIDERATION WHEREOF, it is now hereby ordered and adjudged by this Court that the appeal in the above-styled and numbered cause be and the same is hereby DISMISSED;

It is further ordered that movant-appellant pay defendants-appellees the costs on appeal to be taxed by the Clerk of this Court.

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*Honorable Levin H. Campbell, Senior U. S. Circuit Judge for the First Circuit, sitting by designation.

Entered: January 31, 1996
For the Court: Miguel J. Cortez, Clerk

By: /s/ Mathew Davidson
Deputy Clerk

ISSUED AS MANDATE: 4-5-96

IN THE UNITED STATES COURT OF APPEALS
FOR THE ELEVENTH CIRCUIT

No. 95-6013

RICKY WYATT, by and through his Aunt and Legal Guardian, Mrs. W. C. Rawlins, Jr., GLENDA BRANDNER, by and through her husband and legal guardian, Wolfgang Brandner, DAVIS S. SCHOEL, by and through his father and legal guardian, J. FRED SCHOEL, Dr., D. A. R. PEYMAN, JR., JOSEPH L. MOUDRY, BRENDA N. STACEY, WILLIAM HOLDEN, JR., AMELIA B. HEATH, for themselves and all others similarly situated,

Plaintiffs,

DIANE MARTIN, MARY BETH PARKER, WILLIAM SMITH, ADELIA KEEBLER, MICHAEL GUINS, RICHARD MILLS, KIM SMELLEY, FRANKIE HOPKINS, KENNETH COOK, WAYNE WILLIAMS,

Intervenors,

WILLIAM HAAS, as Guardian and next friend of BRIDGET ANN HAAS,

Movant-Appellant,

versus

RICHARD E. HANAN, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, HENRY STEAGALL, individually and in his capacity as Director of Finance for the State of Alabama, TOM BRASSELL, individually and in his capacity as Comptroller of the State of Alabama, ANNIE LAURIE GUNTER, individually and in her capacity as Treasurer of the State

of Alabama, KEN WALLIS, as Receiver of the mental illness and mental retardation operation,

Defendants-Appellees,

UNITED STATES OF AMERICA,

Amicus.

On Appeal from the United States District Court
for the Middle District of Alabama

(Filed Mar. 28, 1996)

ON PETITION(S) FOR REHEARING AND
SUGGESTION(S) OF REHEARING EN BANC
(Opinion ___, 11th Cir., 19___, ___ F.2d ___).

BEFORE: TJOFLAT, Chief Judge, RONEY and CAMPBELL*, Senior Circuit Judges.

PER CURIAM:

The Petition(s) for Rehearing are DENIED and no member of this panel nor other Judge in regular active service on the Court having requested that the Court be polled on rehearing en banc (Rule 35, Federal Rules of Appellate Procedure; Eleventh Circuit Rule 35-5), the Suggestion(s) of Rehearing En Banc are DENIED.

ENTERED FOR THE COURT:

/s/ Gerald Bard Tjoflat
CHIEF JUDGE

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*Honorable Levin H. Campbell, Senior U.S. Circuit Judge for the First Circuit, sitting by designation.

IN THE DISTRICT COURT OF THE
UNITED STATES FOR THE
MIDDLE DISTRICT OF ALABAMA,
NORTHERN DIVISION

RICKY WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., et al.,

Plaintiffs,

DIANE MARTIN, et al.,

Plaintiff-Intervenors,

v.

RICHARD E. HANAN, as Commissioner of Mental Health and Mental Retardation, and the State of Alabama Mental Health Officer, et al.,

Defendants,

UNITED STATES OF AMERICA,

Amicus Curiae.

CIVIL ACTION NO. 3195-N

(Filed Feb. 15, 1995)

ORDER

This lawsuit is before the court on a motion to intervene filed by William Edward Haas, as next friend and legal guardian of his daughter, a mentally incompetent woman who is now a resident of one of the State of Alabama's institutions for the mentally retarded and mentally ill. For the reasons that follow, the court concludes that Haas's motion should be denied.

I. BACKGROUND

The plaintiffs filed this class-action lawsuit in 1970 claiming that conditions in Alabama's institutions for the mentally ill and the mentally retarded violated the patients' constitutional rights. In 1972, the court found in favor of plaintiffs and entered injunctions requiring officials of the Alabama Department of Mental Health and Mental Retardation to bring their facilities into compliance with certain minimal constitutional standards. *Wyatt v. Stickney*, 344 F. Supp. 373 (M.D. Ala. 1972) (standards for mentally ill), *aff'd in relevant part*, 503 F.2d 1305 (5th Cir. 1974); *Wyatt v. Stickney*, 344 F. Supp. 387 (M.D. Ala. 1972) (standards for mentally retarded), *aff'd in relevant part*, 503 F.2d 1305 (5th Cir. 1974). Fourteen years later, on September 22, 1986, the court approved a consent decree that resolved the plaintiffs' and the defendants' continued conflicts over the adequacy of the state's funding and administration of facilities under the court-ordered standards.[1] In 1991, a new round of litigation began. On January 18, 1991, the defendants filed a motion for a finding that they have met their obligations under the 1986 consent decree and for an order terminating this lawsuit. On January 22, 1993, the plaintiffs responded by filing a motion to enforce the 1986 consent decree and for further relief based on the consent decree and the Americans with Disabilities Act of 1990, 42 U.S.C.A.

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[1] The consent decree is reproduced at *Wyatt v. Wallis*, No. 3195-N, 1986 WL 69194 (M.D. Ala. Sept. 22, 1986). Modifications of the court-ordered standards have also been approved. *See, e.g., Wyatt v. King*, 793 F. Supp. 1058 (M.D. Ala. 1992).

§§ 12101-12213. The motions are set for trial in March 1995.[2]

It is within this context, after 24 years of litigation and court involvement with the Alabama Mental Health and Mental Retardation Systems, that Haas seeks to intervene on behalf of his daughter.[3]

II. DISCUSSION

A.

Haas seeks to intervene as a matter of right and, alternatively, as a matter of discretion, based on Rule 24 of the Federal Rules of Civil Procedure. Under subsection (a)(2) to Rule 24, a party seeking to intervene as a matter of right must meet the following requirements: (1) the application must be timely; (2) the interest asserted must relate to the property or transaction that is the subject of the action; (3) the applicant must be situated such that disposition of the action may impede or impair the applicant's ability to protect that interest; and (4) the interest asserted must be represented inadequately by the existing

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[2] These motions were previously set for trial in January 1995.

[3] Haas seeks to represent his daughter pursuant to Rule 17(c) of the Federal Rules of Civil Procedure, which provides that, "Whenever an infant or incompetent person has a representative, such as a general guardian, committee, conservator, or other like fiduciary, the representative may sue or defend on behalf of the infant or incompetent person."

parties to the lawsuit.[4] *Chiles v. Thornburgh*, 865 F.2d 1197, 1213 (11th Cir. 1989). If these four requirements are all met, intervention must be granted. *Id.* at 1213. If any of these requirements is not met, the intervention as of right is not proper. *Bush v. Viterna*, 740 F.2d 350, 354 (5th Cir. 1984). Because Haas has failed to satisfy the fourth requirement – that is, he has not proved that the interests he seeks to assert are not already adequately represented – the court discusses only this requirement and does not reach whether the other requirements are satisfied.

The requirement that an intervenor not be adequately represented by existing parties "is satisfied if the applicant shows that representation of his interest 'may be' inadequate; and the burden of making that showing should be treated as minimal." *Trbovich v. United Mine Workers*, 404 U.S. 528, 538 n. 10, 92 S.Ct. 630, 636 n. 10 (1972). "However 'minimal' this burden may be, it cannot be treated as so minimal as to write the requirement completely out of the rule." *Bush*, 740 F.2d at 355. " 'When the party seeking intervention has the same ultimate objective as a party to the suit, a presumption arises that its interests are adequately represented, against which the

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[4] Subsection (a)(2) to Rule 24 provides:

"Upon timely application anyone shall be permitted to intervene in an action: . . . when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties."

petitioner must demonstrate adversity of interest, collusion, or nonfeasance.' " *Id.* (*quoting Commonwealth of Virginia v. Westinghouse Electric Corp.*, 542 F.2d 214, 216 (4th Cir. 1976)) (intervening citations omitted). The party seeking intervention must "contribute" something to the "lawsuit beyond underlining the positions already taken" by the current parties. *Bush*, 740 F.2d at 357.

Haas's daughter is a profoundly mentally retarded resident of the William D. Partlow Developmental Center in Tuscaloosa, Alabama. She is 30-years old and has the mental ability of an 18-month-old child. Haas asserts in his proposed complaint-in-intervention that, under both federal and state law, his daughter is entitled "to continue to receive, at Partlow, care of the type currently provided by Partlow,"[5] "subject to reasonable improvements as indicated by medical science."[6] He concludes his complaint-in-intervention with the allegation that "certain organizations and entities styled as parties-plaintiffs have urged this court to decrease the services offered at Partlow or to close Partlow."[7] Haas is essentially asking that the defendants be enjoined (1) to keep Partlow open and to continue to provide needed individual care to his daughter at that facility and (2) to continue to make the necessary improvements of the facility and programs at Partlow as long as she is a resident there.[8]

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[5] Haas's proposed complaint-in-intervention ¶¶ 14 & 15 (attached to his motion to intervene filed on September 21, 1994, (Doc. no. 131)).

[6] *Id.* at p. 4.

[7] *Id.* at ¶ 16.

[8] Haas's brief filed on October 7, 1994, at 11 (Doc. no. 197).

The court acknowledges and the parties do not challenge that Haas's daughter has a "direct, substantial, legally protectible interest" in this litigation, *Chiles*, 865 F.2d at 1214, as do all residents of the Alabama Mental Health and Mental Retardation System. The critical question instead is whether this interest is not being already adequately pursued and litigated by the current parties to this lawsuit. Haas divides his interest – which, of course, he asserts on behalf of his daughter – into the following three parts: (1) his daughter's interest in remaining a resident at the Partlow facility, because only Partlow can provide effective and adequate habilitation for her and similarly situated profoundly retarded and mentally incompetent persons; (2) her interest in having the defendants maintain and improve the Partlow facility and habilitation programs; and (3) her right to participate directly in the decision-making process that materially affects her own future.

It is apparent from Haas's brief in support of his motion to intervene that his principal concern is that the defendants not be allowed to close Partlow and that his daughter be allowed to remain a patient there indefinitely. Haas challenges the "overall course of conduct" required of the defendants by the 1986 consent decree and by some of the *Wyatt* standards reaffirmed by that decree.[9] He criticizes the defendants for having entered into the 1986 decree and for having acquiesced to certain court orders rejecting the defendants' efforts to have some of the *Wyatt* standards modified or eliminated.[10]

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[9] *Id.* at 9.

[10] *Id.* at 8 & 9 nn. 7 & 8.

See, e.g. Wyatt v. King, 811 F. Supp. 1533 (M.D. Ala. 1993); *Wyatt v. King*, 803 F. Supp. 377 (M.D. Ala. 1992). In particular, he takes issue with that provision in the 1986 consent decree that requires the defendants "to continue to make substantial progress in placing members of the plaintiff class in community facilities and programs,"[11] and with those *Wyatt* standards that require that patients receive treatment in the "least restrictive conditions necessary."[12] The validity of any earlier decree or order is

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[11] *Wyatt v. Wallis*, No. 3195-N, 1986 WL 69194, at *7 (M.D. Ala. Sept. 22, 1986).

[12] Haas takes issue with the following standards governing the mentally retarded:

> (a) the requirement that "no person shall be admitted to the institution unless a prior determination shall have been made that residence in the institution is the least restrictive habilitation setting feasible for that person" (Standard II-3(a));
>
> (b) the requirement that "no mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person" (Standard II-3(b));
>
> (c) the requirement that each resident's individualized treatment plan shall contain "a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident" (Standard III-9(d)), and "criteria for release to less restrictive settings for habilitation" (included in Standard III-9(f)); and
>
> (d) the requirement that the staff member supervising implementation of the treatment plan "shall also be responsible for ensuring that the patient is released when appropriate to a less restrictive habilitation setting" (included in Standard III-11).

Wyatt, 344 F. Supp. at 396-98.

simply not at issue in the upcoming litigation. Haas therefore has no right to intervene to challenge these earlier orders.

Haas contends next that the plaintiffs and the defendant "may or may not" take the position that Partlow is the "least restrictive setting" for his daughter.[13] Admittedly, the plaintiffs and the defendants are now engaged in a dispute over the defendants' obligation to place patients in the "least restrictive environment" and, where appropriate, in "community facilities." But as to this dispute, Haas has not shown that he has "has anything to contribute to this lawsuit beyond underlining the positions already taken by" the current parties. *Bush*, 740 F.2d at 357. He suggests that he has "both general and specific proposals with regard to the operation of Partlow by the Defendants, proposals that other Plaintiffs may neither imagine nor support," but he has not identified these proposals.[14] He has therefore not identified a single issue that would not be litigated or single position that would not be advanced in his absence.

This is therefore "not a suit in which no existing party has voiced applicant's concerns," *Bush*, 740 F.2d at 357; "this is not a case where the applicant has a defense not available to the present defendant," *id.*; "this is not a suit in which it is clear that the applicant will make a more vigorous presentation of arguments than existing parties," *id.*; "this is not a suit in which no party views the applicant's claims favorably," *id.*; "this case is more

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[13] Haas's brief filed on October 7, 1994, at 9 (Doc. no. 197).

[14] *Id.* at 11.

closely aligned with those cases in which courts have determined that the burden of showing inadequacy of representation has not been met." *Id.* Indeed, a review of the record in this lawsuit indicates that the ongoing battle between parties over the issues of "least restrictive environment" and "community placement" is detailed, sincere, and vigorously adversarial; these issues are, if anything, being over-litigated.

Haas further complains that the plaintiffs and the defendants may in the future enter into a settlement that is adverse to the interest of his daughter. He states that it is "by no means impossible that the Defendants and . . . the Plaintiffs may at some time concur – albeit for significantly different reasons – in denying the desirability (or even the propriety) of maintaining persons in residence at Partlow."[15] "However, the mere possibility that a party may at some future time enter into a settlement cannot alone show inadequate representation." *Bush*, 740 F.2d at 358.

Similarly, Haas has not shown that the current parties are inadequately pursuing his daughter's interest in having the defendants maintain and improve the Partlow facility and habilitation programs. Again, he has not identified a single issue that would not be litigated or single position that would not be advanced in his absence.

Finally, Haas's interest in participating directly in the decision-making process that materially affects his daughter's own future begs the question as to whether

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[15] *Id.* at 11.

the current parties are adequately representing his daughter's interest as to the issues now before the court. As already shown above, the parties are adequately representing her interests.[16]

B.

As stated, Haas also seeks to intervene as a matter of the court's discretion pursuant to subsection (b)(2) of Rule 24.[17] The court has discretion to allow intervention if an applicant can show that (1) the application to intervene is timely and (2) the claim or defense to be asserted and the main action have a question of law or fact in common. *Chiles*, 865 F.2d at 1213. The litigation before the court is a complex class-action lawsuit involving the

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[16] Haas suggests that he should be allowed to intervene because none of the named class representatives is a resident of Partlow. Nevertheless, he has still not shown that his daughter's interests are not be adequately pursued; and, at an in-chambers conference on January 6, 1995, he voiced no desire to be a class representative. In any event, the issues of the need for new class representatives and whether the current class representatives need to be replaced are now being separately addressed in motions filed by the defendants. *See* defendants' motion to recertify or modify the plaintiff class, filed on December 22, 1994 (Doc. no. 417), and their supplement to said motion, filed on January 18, 1995 (Doc. no. 456).

[17] Subsection (b)(2) of Rule 24 provides in part:

> "Upon timely application anyone may be permitted to intervene in an action: . . . when an applicant's claim or defense and the main action have a question of law or fact in common. . . . . In exercising its discretion the court shall consider whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties.

entire Alabama Mental Health and Mental Retardation System. To allow representatives of all residents who have an interest in this litigation – that is, all representatives – to intervene would render this lawsuit more unmanageable and unnecessarily confusing than it already is.

C.

It is apparent that the real concern behind Haas's motion is that, in light of past agreements entered into between the parties, he is unwilling to continue to rely on the plaintiffs or the defendants to protect the interests of his daughter, and that he essentially wants to "be able to monitor effectively" for himself the actions of the parties.[18] The court finds no fault with Haas's concern. As this court has previously stated, the plaintiff class members whose interests are at stake in this litigation are unlikely to be able to "voice" those interests themselves. *Wyatt v. Horsley*, 793 F. Supp. 1053, 1056 (M.D. Ala. 1992). In order to recognize and give due consideration to those interests, the court and the parties must look to "such secondary sources as public interest organizations, former mental patients, and family members and caregivers who have day-to-day contact with class members in the state's institutions." *Id.* Therefore, although it is not feasible that Haas and other similarly concerned family members, caregivers, and guardians all be made parties to this

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[18] Haas's brief filed on October 7, 1994, at 10 (Doc. no. 197).

litigation, their close monitoring of this litigation, including the actions of the plaintiffs and the defendants, is encouraged and welcomed by the court.

Accordingly, it is ORDERED that the motion for leave to intervene, filed on September 21, 1994, by William Edward Haas, as next friend and legal guardian of his daughter, is denied.

DONE, this the 15th day of February, 1995.

/s/ Myron H. Thompson
UNITED STATES DISTRICT JUDGE

Ricky WYATT, By and Through his aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., etc., Plaintiffs-Appellees,

v.

Charles ADERHOLT, as Commissioner of Mental Health, et al., Defendants, The Alabama Mental Health Board, an Agency of the State of Alabama, and George C. Wallace, as Governor of Ala., Defendants-Appellants.

No. 72-2634.
United States Court of Appeals, Fifth Circuit.
Nov. 8, 1974.

Charles M. Crook, Montgomery, Ala., for Gov. Wallace.

William Baxley, Atty. Gen., George Beck, Deputy Atty. Gen., Montgomery, Ala., for Ala. Mental Health Board.

George W. Dean, Jr., Destin, Fla., Shelly Mercer, Nat'l. Health & Environmental Program, School of Law, UCLA, Los Angeles, Cal., Jack Drake, Tuscaloosa, Ala., Morton Birnbaum, Brooklyn, N.Y., for plaintiffs-appellees.

Paul Friedman, Patricia M. Wald, Mental Health Law Project, Washington, D.C., for Nat. Council on the Rights of the Mentally Impaired.

Bruce Ennis, New York City, for NCRMI & Am. Psy. Assoc., and others.

Stanley Herr, NLADA, Nat. Law Office, James F. Fitzpatrick, Jeffrey Bauman, Washington, D.C., Ira DeMent, U.S. Atty., Kenneth E. Vines, Asst. U.S. Atty., Montgomery, Ala., Edward Lynch, President's Committee on Mental Retardation, Washington, D.C., for United States.

Robert H. Johnson, Atty., Civil Rights Div., U.S. Dept. of Justice, Louis M. Thrasher, Associate Director, Washington, D.C., for United States, amicus curiae.

Charles R. Halpern, Center for Law & Social Policy, Washington, D.C., for Mental Health Law Project, amicus curiae.

Warren E. Magee, Washington, D.C., for Amer. Psychiatric Association, amicus curiae.

Sheridan Neimark, Washington, D.C., for NSAC, amicus curiae.

Before WISDOM, BELL and COLEMAN, Circuit Judges.

WISDOM, Circuit Judge:

In this case, we must decide whether federal district courts have the power to order state mental institutions to provide minimum levels of psychiatric care and treatment[1] to persons civilly committed to the institutions.

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[1] 'Treatment' means care provided by mental health professionals and others that is adequate and appropriate for the needs of the mentally impaired inmate. Treatment also encompasses a humane physical and psychological environment. The term 'habilitation', used by the parties and amici in the district court and by the district court in its order of April 13, 1972 (Partlow State School and Hospital) is a term used to describe that treatment which is appropriate to the condition of the mental retardate. For convenience, in this opinion we group 'habilitation' and 'treatment' under the single term 'treatment', and to include those instances where rehabilitation is impossible in which event the requirement is minimally adequate habilitation and care, beyond the subsistence level

The guardians of patients civilly committed to three Alabama facilities for the mentally handicapped brought this class action on behalf of their wards and other civilly committed patients at those institutions. The Honorable Frank M. Johnson, trial judge, held that mentally ill patients 'have a constitutional right to receive such individual treatment as will give each of them a reasonable opportunity to be cured or to improve his or her mental condition'. *Wyatt v. Stickney*, M.D.Ala.1971, 325 F.Supp. 781, 784. In a later order, Judge Johnson held that the mentally retarded patients have a constitutional right to 'such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society'. *Wyatt v. Stickney*, M.D.Ala.1972, 344 F.Supp. 387, 390. The district court found that conditions at the three facilities deprived the plaintiffs of these constitutional rights, and ordered the defendants-appellants, Alabama officials responsible for the administration of the state's mental health programs, to implement a detailed set of standards designed to ensure the provision of minimally adequate treatment and habilitation at the institutions. From this order, the Alabama Mental Health Board and Alabama's Governor George C. Wallace bring separate appeals.

Together, the Mental Health Board and the Governor advance six major contentions on appeal. They contend (1) that the district court erred in holding that civilly committed mental patients have a constitutional right to treatment; (2) that the court lacked jurisdiction because

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custodial care that would be provided in a penitentiary. *Donaldson v. O'Connor*, 5 Cir., 1974, 493 F.2d 507, 522.

the suit was in effect a suit against the state proscribed by the eleventh amendment; (3) that the case involves rights and duties not susceptible to determination by judicially ascertainable and manageable standards, and therefore presents a non-justiciable controversy; (4) that the order of the district court invades a province of decision-making exclusively reserved to the state legislature; (5) that the plaintiffs were not entitled to equitable relief because they had adequate remedies at law to protect the rights they asserted; and (6) that the district court erred in awarding plaintiffs a reasonable attorneys' fee.

Neither in the district court nor on appeal to this Court have the defendants challenged the detailed set of standards articulated by the district court. They have conceded that if there is a constitutional right to treatment enforceable by a suit for injunctive relief in federal court, those standards accurately reflect what would be required to ensure the provision of adequate treatment.

I.

A. The proceedings below

This case began innocuously enough, when a cut in the Alabama cigarette tax forced the state to fire 99 professional, subprofessional, and intern employees[2] at the

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[2] The 99 employees included 41 who were assigned duties such as food service, maintenance, typing and other mechanical duties not involving direct patient care; 26 persons involved in planning social and other recreational activities for the patients; nine persons from the department of psychology; eleven from the social service department; three registered nurses, two physicians, one dentist, and six dental aides.

Bryce Hospital, a state-run institution for the mentally ill at Tuscaloosa. The plaintiffs filed their complaint October 23, 1970. The complaint named two classes as plaintiffs. One, represented by Ricky Wyatt and two other named plaintiffs, appellees here, consisted of the patients at Bryce. The other, represented by five of the then recently terminated employees, consisted of the employees who had been dismissed for budgetary reasons. The defendants were Stonewall B. Stickney, then Executive Officer of the Alabama State Mental Health Board; Dr. John V. Hottel, his Chief Deputy; the members of the Board; then Governor Albert P. Brewer, both in his capacity as Governor and in his capacity as a member of the Board; and Judge Perry O. Hooper, Probate Judge of Montgomery County, both individually and as a representative of the class consisting of all probate judges in Alabama.

The complaint alleged that the defendants had effected the staff reductions purely for budgetary reasons; that the discharges of the 99 employees had been accomplished without notice and a hearing, and violated the employees' rights under the due process clause; and that as a result of the discharges the patients at Bryce would not receive adequate treatment. The complaint sought injunctive relief requiring the defendants to insure that treatment programs then being administered at Bryce would not be interrupted or altered, and requiring the defendants to rescind the terminations of the 99 employees.

The original complaint did not allege that treatment levels at Bryce had been inadequate before the terminations. For reasons not entirely clear from the record before us, however, the focus of the litigation soon shifted

from the effects of the October 1970 terminations to questions of the overall adequacy of the treatment afforded at the Alabama state mental hospitals. On January 4, 1971, the plaintiffs amended the complaint to add prayers that the defendants be enjoined from operating Bryce 'in a manner that does not conform to constitutional standards of delivering adequate mental treatment to its patients'; that the Court order defendants to prepare a 'comprehensive constitutionally acceptable plan to provide adequate treatment in any state mental health facility'; and that the court declare that patients confined to a state mental helath [sic] facility are entitled to 'adequate, competent treatment'.

On March 12, 1971, the district court ruled on the plaintiffs' motion for a preliminary injunction. 325 F.Supp. 781. The court's opinion reflected the shift in the focus of the case. In its opinion, the court declared that patients 'involuntarily committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings' are 'committed for treatment purposes' and so 'unquestionably have a constitutional right to receive such individual treatment as will give each of them a relaistic opportunity to be cured or to improve his or her mental condition'. 325 F.Supp. at 784. The court found that the treatment programs in effect before the institution of a staff reorganization then in progress were 'scientifically and medically inadequate', failing to 'conform to any known minimums established for providing treatment for the mentally ill'. Id. The court stated that it was not at that time in a position to determine whether the treatment which would be provided after the reorganization was completed would be adequate. Accordingly, the court allowed the defendants ninety days to report progress made in the reorganization

plan, and to file with the Court a 'specific plan' for the provision of adequate treatment at Bryce. Also in the March 12 order, the court invited the United States, through the Department of Justice and Health, Education and Welfare, to appear as amicus.

On August 4, 1971, the plaintiffs amended their complaint to allege that the Search [sic] Hospital at Mount Vernon, Alabama, the one other state hospital for the mentally ill in Alabama, and the Partlow State School and Hospital, Alabama's state facility for the mentally retarded, were being operated in a constitutionally impermissible manner.

On September 13, 1971, six months after the March 12 order, the defendants filed their report on proposed standards of adequate treatment and their implementation. Objections to the report were later filed by the plaintiffs and by the United States, as well as by several interested private organizations which had been granted leave to appear as amici.[3]

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[3] By order entered August 20, 1971, the district court granted the motion filed by the American Civil Liberties Union, the American Orthopsychiatric Association, the American Psychological Association, and the American Association on Mental Deficiency, for leave to appear as amici. In this Court, these amici have been joined by the National Association for Mental Health, the American Psychiatric Association and the National Association for Retarded Children. The seven have filed a joint brief in this Couirt [sic].

> The district court expressed its gratitude to these organizations for their valuable assistance in this difficult and complex case, 344 F.Supp. 375, 390, and we do so, too.

The court announced its conclusions upon review of the report and the objections to it in an opinion issued December 10, 1971. 334 F.Supp. 1341. In this opinion, the district court held that there are three 'fundamental conditions for adequate and effective treatment': a 'humane physical and psychological environment'; qualified staff 'in numbers sufficient to administer adequate treatment'; and individualized treatment plans. The court held that the reports before it showed 'rather conclusively' that the treatment programs at Bryce did not meet any of these conditions. It also noted that conditions at Searcy and Partlow seemed little better. It concluded that the defendants had failed to 'formulate minimum medical and constitutional standards for the operation of these institutions'. The court scheduled a formal hearing to take evidence necessary to establish standards, and said that after the hearing it, the court, would itself 'establish standards and in due course order their implementation'.

The court postponed the hearings to give the defendants another opportunity to formulate proposed minimum standards. On January 17, 1972, the parties and amici met in Atlanta, Georgia, where they undertook extensive discussions concerning the proper standards of treatment at the Alabama hospitals. Out of these discussions came two Memoranda of Agreement stipulating certain of the standards necessary to define what would constitute minimally adequate mental treatment at a state psychiatric institution. One of the Memoranda covered standards for treatment at the mental hospitals, Searcy and Bryce; the other covered standards to be imposed at the school for the mentally retarded, Partlow. These Memoranda were filed with the district court at the times

for the hearings set for determining the proper standards. The hearing concerning Bryce and Searcy was held February 3 and 4, 1972; the hearing concerning Partlow was held February 28-March 2.[4]

The district court announced its orders granting permanent injunctive relief in two opinions issued April 13, 1972. One of the opinions concerned Partlow, the other, Bryce and Searcy. 344 F.Supp. 373 (*Bryce-Searcy*), 390 (*Partlow*). In *Partlow*, Judge Johnson held that 'because the only constitutional justification for civilly committing a mental retardate . . . is habilitation, it follows ineluctably' that civilly committed retardates 'have a constitutional right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society'. The *Bryce-Searcy* opinion summarized the court's earlier opinions, noting its holding that the civilly mentally ill have a constitutional right to treatment. Beyond this, the two

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[4] At the conclusion of the Partlow hearing, the district court entered an emergency order requiring the defendants to take certain immediate actions at Partlow. These included the installation of an emergency light system and procedures for emergency evacuation; revision of sanitation measures in the kitchen; revamping of its program for the use of drugs; conducting appropriate immunizations; and employing three hundred additional resident care workers. In its order filed March 2, 1972, the court said it was taking these steps 'to protect the lives and well-being of the residents', because it found Partlow to be a 'warehousing institution . . . wholly incapable of furnishing treatment to the mentally retarded and . . . conducive only to the deterioriation and debilitation of the residents', and because it found conditions at Partlow 'substandard to the point of endangering the health and lives of the residents'.

opinions were substantially identical. Both ordered the defendants (1) to implement an elaborate set of standards of treatment set forth in appendices to the opinions; (2) to establish human rights committees at the institutions to review all research and treatment programs 'to ensure that the dignity and human rights of the residents are preserved'; (3) to prepare and file reports within six months of the orders on the implementation of the standards; and (4) to pay court costs and a reasonable attorneys' fee to the plaintiffs. The *Partlow* order also required the defendants to hire a qualified administrator for the School within sixty days.[5]

Governor Wallace and the Mental Health Board filed separate notices of appeal May 12, 1972. On May 22, Governor Wallace filed a motion for modification and for a stay pending appeal. On June 1, the district court issued an opinion fixing the amount due plaintiffs as attorneys' fees at $36,744.62. 344 F.Supp. at 408-411. On June 26, the district court denied the motions for modification and for

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[5] In both orders, the court refused requests made by plaintiffs and amici to appoint a master and professional advisory committee to oversee implementation of the standards on grounds that 'federal courts are reluctant to assume control of any organization, but especially one operated by a state'. 344 F.Supp. at 377, 392-393. The court also, in both orders, reserved ruling on various motions by the plaintiffs to ensure adequate financing for the implementation of the standards. These included a motion that the Mental Health Board be directed to sell or encumber its extensive land holdings, and a motion for an injunction against the expenditure of state funds on any 'nonessential' functions until the standards were fully implemented.

a stay pending appeal. This Court also denied a motion for a stay pending appeal.

B. The conditions in the Alabama hospitals

There has not been any significant dispute, in this Court or in the district court, about the conditions that prevailed in the Alabama hospitals at the time this suit was instituted. The defendants have pitched their defense on their argument that the Constitution does not guarantee a right to treatment; they have virtually conceded that if such a constitutional right exists, the conditions in the hospitals were such that the state's constitutional obligation to provide adequate treatment could not be met. There is therefore little reason for an extended discussion of the conditions that prevailed at the hospitals. Some discussion, however, is essential to understanding this case. We therefore note briefly how far short the hospitals fell of meeting the three 'fundamental conditions of adequate and effective treatment' defined by the district court.

First, it is clear that the environment at the hospitals was a far cry from the 'humane psychological and physical environment' the district court envisioned as sine qua non of rehabilitative treatment. Bryce Hospital was built in the 1850's; it had 5000 inmates of whom 1500 to 1600 were geriatrics, 1000 were mental retardates, and there were allegedly other non-mentally ill persons. Patients in the hospitals were afforded virtually no privacy: the wards were overcrowded; there was no furniture where patients could keep clothing; there were no partitions between commodes in the bathrooms. There were severe

health and safety problems: patients with open wounds and inadequately treated skin diseases were in imminent danger of infection because of the unsanitary conditions existing in the wards, such as permitting urine and feces to remain on the floor; there was evidence of insect infestation in the kitchen and dining areas. Malnutrition was a problem: the United States described the food as 'com(ing) closer to 'punishment' by starvation' than nutrition. At Bryce, the food distribution and preparation systems were unsanitary, and less than 50 cents per day per patient was spent on food. Dr. Donald L. Clopper, Associate Commissioner for Mental Retardation for the Alabama Department of Mental Health, testified that Partlow was a 'stepchild' in the State of Alabama; that the physical environment was inadequate for treating inmates; that 'we don't have the staff we don't have the facilities, nor do we have the financial resources'. According to Dr. Clopper, at least 300 Partlow inmates could be discharged immediately, and about 70 percent of the inmates should never have been committed; yet it was 60 percent over-crowded. Patients at Partlow were forced to perform uncompensated labor. Aides frequently put patients in seclusion or under physical restraints, including straitjackets, without physicians' orders. One resident had been regularly confined in a straitjacket for more than nine years. The Evaluation Report on Partlow by the American Association on Mental Deficiency stated that nine working residents would feed 54 young boys ground food from one very large bowl with nine plates and nine spoons; 'since there were no accommodations to even sit down to eat,' it was impossible to tell which residents had been fed and which had not been fed with this

system. Seclusion rooms were large enough for one bed and a coffee can, which served as a toilet. The patients suffered brutality, both at the hands of the aides and at the hands of their fellow patients; testimony established that four Partlow residents died due to understaffing, lack of supervision, and brutality.[6]

The hospitals failed to meet the second condition, adequate staffing. The defendants' chief witness on standards maintained that treatment could be delivered with the ratio of one psychiatrist, one graduate level psychologist, and one masters level social worker for every 125 patients, and the district court ultimately adopted this recommendation. The organizations appearing as amici had recommended higher ratios – one psychiatrist, one psychologist, and one social worker for every 30-50 patients. But at the time this suit was instituted there were ratios of only one medical doctor with some psychiatric training for 5,000 patients, one Ph.D. psychologist for every 1,670 patients, and one masters level social worker for every 2,500 patients at Bryce. The parties and amici agreed completely on the minimums necessary for treatment of the mentally retarded. They agreed that adequate treatment could be delivered at Partlow with ratios of one masters level psychologist and one masters level social worker for every sixty patients, and one physician for every two hundred patients. Yet at Partlow

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[6] One of the four died after a garden hose had been inserted into his rectum for five minutes by a working patient who was cleaning him; one died when a fellow patient hosed him with scalding water; another died when soapy water was forced into his mouth; and a fourth died from a self-administered overdose of drugs which had been inadequately secured.

there were only one psychologist with masters level training or above for every 1,200 patients; one masters level social worker for every 730 patients; and one physician for every 550 patients. Of the four physicians at Partlow, two were not licensed to practice in Alabama.

A severe shortage of nonprofessional staff paralleled the inadequacies of professional staff. After a tour of Bryce, defendants' own consultants noted that:

Aide staff is spread very thin, creating extreme stresses for individual aides, who at times must cover one or two or three wards, housing as many as 100 or 200 patients. Obviously, it is impossible under such circumstances to provide anything more than a cursory observation and the hope of avoiding disturbing incidents. An aide under these circumstances is hard pressed to meet even minimum patient needs.

The institutional staff was inadequate not only in sheer numbers but also in training; there was no effective 'inservice training' program for, or even any regular supervision over, the nonprofessionals.

Finally, the evidence established that the hospitals failed to meet the third condition, individualized treatment programs. According to one consultant's testimony, care of patients at Partlow was not suited to the needs of particular individuals, but was instead 'geared primarily to housekeeping functions – cleaning floors, cleaning beds, cleaning patients – and to a continuation of work assignments'. Experts testified that the patient records kept at the hospital were wholly inadequate; that they were written in such a way as to be incomprehensible to the aide level staff that had prime responsibility for

patient care; and that they were kept where they were not accessible to the direct care staff particularly in need of them.

II.

The appellants' first and principal contention on appeal is that the Constitution does not guarantee persons civilly committed to state mental institutions a right to treatment.[7] This contention is largely foreclosed by our decision, issued since the institution of this appeal, in *Donaldson v. O'Connor*, 1974, 493 F.2d 507. In *Donaldson*, we held that civilly committed mental patients have a constitutional right to such individual treatment as will help each of them to be cured or to improve his or her mental condition. We reasoned that the only permissible justifications for civil commitment, and for the massive abridgments of constitutionally protected liberties it

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[7] In raising the issue in this Court, the appellants contend that, because there is no constitutional right to treatment, the district court lacked jurisdiction over the suit. In so arguing the issue, the appellants are following, on this point as one the other four of their first five contentions, the decision of the Northern District of Georgia in *Burnham v. Department of Public Health*, 1972, 349 F.Supp. 1335, appeal docketed, No. 72-3110, 5 Cir., Oct. 4, 1972. In *Burnham*, the court held that the Constitution does not guarantee a right to treatment. It then held that the consequence of this conclusion was that it was without jurisdiction over the suit, because 28 U.S.C. 1343(3), the asserted basis of jurisdiction, confers jurisdiction only over 'action(s) . . . to redress the deprivation' of a 'right, privilege, or immunity' secured by the Constitution or by an Act of Congress providing for equal rights.

entails, were the danger posed by the individual committed to himself or to others, or the individual's need for treatment and care. We held that where the justification for commitment was treatment, it offended the fundamentals of due process if treatment were not in fact provided; and we held that where the justification was the danger to self or to others, then treatment had to be provided as the quid pro quo society had to pay as the price of the extra safety it derived from the denial of individuals' liberty.

Our discussion in *Donaldson,* briefly summarized here, answers most of the arguments made by the appellants on this appeal against the recognition of a constitutional right to treatment. Governor Wallace, however, makes one argument not answered by our discussion in *Donaldson,* and it is appropriate that we address that argument here. Governor Wallace challenged the assumption, made by the district court in this case and by this Court in *Donaldson,* that the only permissible justifications for confinement are danger to self or others or need for treatment. Instead, the Governor suggests, the principal justification for commitment lies in the inability of the mentally ill and mentally retarded to care for themselves. The essence of this argument is that the primary function of civil commitment is to relieve the burden imposed upon the families and friends of the mentally disabled. The families and friends of the disabled, the Governor asserts, are the 'true clients' of the institutionalization system.[8]

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[8] Governor Wallace borrows the term 'true clients' from the work of Professor Erving Goffman. E. Goffman, Asylums –

From this premise the Governor proceeds to the conclusion that is the crux of his argument. If 'need for care' is a justification for commitment – or is the justification – then it follows that the mere provision of custodial care is constitutionally adequate to justify continued confinement. 'The providing of custodial care alone is a tremendously important consideration to patients, their families, and the public-at-large', the Governor writes in his brief.

There are two answers to this line of argument. The first, and more limited, is that even accepting the Governor's premise that 'need for care' is a constitutionally adequate justification for confinement, it does not follow that we must accept the conclusion – that the kind of care that was provided at the Alabama hospitals is sufficient to make continued confinement constitutional. The assertion that 'need for care' justifies confinement implies that the state has an affirmative obligation to provide a certain minimum quality 'care', no less than the assertion that 'need for treatment' justifies confinement implies that the state has an affirmative obligation to provide a certain

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Essays on the Social Situations of Mental Patients and Other Inmates 384 (1961). Governor Wallace in his brief praises Professor Goffman as a 'realistic writer'. Be that as it may, it is fairly clear that Professor Goffman's intent, in calling 'relatives, police, and judges' the 'true clients of the mental hospitals' was critical, indeed harshly so, and that Professor Goffman was insinuating by that statement an embarrassing, though rarely admitted, truth about the institutionalization system in the United States. What Professor Goffman implied was morally unacceptable – that the convenience of relatives and law enforcers justifies stripping away all of the liberties of the civilly committed we hold today is constitutionally unacceptable.

minimum quality 'treatment'. And it is clear that, however that obligation might specifically be defined, it was not being met in the Alabama hospitals. Dr. Gunnar Dybwad, Professor of Human Development at the Graduate School for Advanced Studies in Social Welfare at Brandeis University, and a one time presidential consultant in the field of mental retardation, made essentially this point when he testified about conditions at Alabama's Partlow State School and Hospital:

> The situation which exists and obviously has existed in Partlow for a long time is one of storage, of persons. I am using that word because I would not use care, which involves – has a certain qualitative character, and I would not even use the word, 'custodial,' because custody, in my term, means safekeeping. And, as is visible to the visitor at the present time, employees at Partlow are not in a position to effect safekeeping, considering the number of people they have to take care of; so I would say it is a storage problem at the moment.

Indeed, many of the standards established by the district court in this case – notably those required for what the district court called a 'humane psychological and physical environment' – might have to be met for the state to be able legitimately to claim it was providing adequate 'care' to its mental patients. At least where the right to a 'humane environment' is concerned, then if it is irrelevant whether the right be viewed as a facet of a 'right to treatment', or of a 'right to care'. It is likewise irrelevant for those purposes whether the state interest imputed to the civil commitment system be called the need 'to treat' the mentally ill, or the need 'to care' for them.

But beyond this, we find it impossible to accept the Governor's underlying premise that the 'need to care' for the mentally ill – and to relieve their families, friends, or guardians of the burdens of doing so – can supply a constitutional justification for civil commitment. At stake in the civil commitment context, as we emphasized in *Donaldson*, see 493 F.2d at 520, are 'massive curtailments' of individual liberty. Against the sweeping personal interests involved, Governor Wallace would have us weigh the state's interest, and the interests of the friends and families of the mentally handicapped in having private parties relieved of the 'burden' of caring for the mentally ill. The state interest thus asserted may be, strictly speaking, a 'rational' state interest. But we find it so trivial beside the major personal interests against which it is to be weighed that we cannot possibly accept it as a justification for the deprivations of liberty involved.

The other arguments against recognition of a constitutional right to treatment for civilly committed mental patients advanced by the appellants are, as we noted above, answered by our discussion in *Donaldson*. Following *Donaldson*, we hold that the district court here did not err in finding that civilly committed mental patients have a constitutional right to treatment. Our express holding in *Donaldson* and here rests on the quid pro quo concept of 'rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary.' 493 F.2d at 522.

III.

The second, third, fourth, and fifth issues raised by the appellants are also substantially affected by our decision in *Donaldson*, and present little difficulty except as to some aspects of remedy which will be discussed in Part IV, infra. The argument that this suit is barred by the eleventh amendment is based largely upon *Burnham v. Department of Public Health*, N.D.Ga. 1972, 349 F.Supp. 1335, appeal docketed, No. 72-3110, 5 Cir., Oct. 4, 1972, a case consolidated for argument on appeal with this case. In *Burnham*, the court held that, because the right to treatment was a right arising only, if at all, under state law, a suit by citizens of the state against state officials to enforce the right was barred by the eleventh amendment. Our holding in *Donaldson*, however, vitiates this argument, of course, for we have now established that the right to treatment arises as a matter of federal constitutional law under the due process clause of the Fourteenth Amendment.

In *Donaldson*, we addressed and rejected the argument that a constitutional right to adequate treatment would present questions not susceptible to 'judicially manageable or ascertainable standards'. We held that the judiciary was competent to determine, at least in individual cases, whether psychiatric treatment was medically or constitutionally adequate. And we said in dictum that even in cases such as this one, 'when courts are asked to undertake the more difficult task of fashioning institution-wide standards of adequacy', 493 F.2d at 526, the courts would be able to formulate workable standards. In *Donaldson*, we took note of the substantial agreement

reached in this case among parties and amici in developing standards during the course of the proceedings in the lower court. We cited that development as evidence supporting our view that workable standards could be fashioned. We remain mindful of that development here, in reaffirming our belief that the right to treatment can be implemented through judicially manageable standards.

The appellants' fourth contention is that the order of the district court invades a province of decision-making exclusively reserved for the state legislature. Governor Wallace argues that the order will require heavy expenditures of state funds; that these funds will have to come from other state programs; and that the duty of compromising and allocating funds among the many programs competing for them is a duty which must be discharged by the state governor and legislature alone. Governor Wallace concedes in his brief that he is not contending that 'the financial cost of complying with an established constitutional right is a valid reason for failure to comply'. He 'suggest(s) that before the Court decides to adopt a new constitutional right it should consider all of the consequences of its action, financial and social, and its effect on our federal form of government'. The Mental Health Board makes the point in a related way, by suggesting that the district court's order here is in effect an order requiring the state to furnish a particular service, and by citing cases establishing the general proposition that ordinarily it is not for the federal courts to say whether or in what amounts a state shall provide any particular government benefit or service. E.g., *Fullington v. Shea*, D.Colo.1970, 320 F.Supp. 500, *aff'd*, 404 U.S. 963, 92 S.Ct. 345, 30 L.Ed.2d 282.

We find these arguments unpersuasive. It goes without saying that state legislatures are ordinarily free to choose among various social services competing for legislative attention and state funds. But that does not mean that a state legislature is free, for budgetary or any other reasons, to provide a social service in a manner which will result in the denial of individuals' constitutional rights. And it is the essence of our holding, here and in *Donaldson*, that the provision of treatment to those the state has involuntarily confined in mental hospitals is necessary to make the state's actions in confining and continuing to confine those individuals constitutional. That being the case, the state may not fail to provide treatment for budgetary reasons alone. 'Humane considerations and constitutional requirements are not, in this day, to be measured or limited by dollar considerations'. *Jackson v. Bishop*, 8 Cir. 1968, 404 F.2d 571, 580 (Blackmun, J.), quoted, *Rozecki v. Gaughan*, 1 Cir. 1972, 459 F.2d 6, 8. 'Inadequate resources can never be an adequate justification for the state's depriving any person of his constitutional rights'. *Hamilton v. Love*, E.D.Ark.1972, 328 F.Supp. 1182, 1194. 'The obligation of the Respondents (prison officials) to eliminate unconstitutionalities does not depend upon what the Legislatures may do'. *Holt v. Sarver*, E.D.Ark.1970, 309 F.Supp. 362, 385, *aff'd*, 8 Cir. 1971, 442 F.2d 304. See also *Hawkins v. Town of Shaw*, 5 Cir. 1971, 437 F.2d 1286, 1292.

This conclusion is not novel. In the context of state penal institutions, the federal courts have repeatedly intervened to assure that the conditions of confinement do not invade the constitutional rights of those confined. E.g., *Cruz v. Beto*, 1972, 405 U.S. 319, 92 S.Ct. 1079, 31

L.Ed.2d 263; *Johnson v. Avery*, 1968, 393 U.S. 483, 89 S.Ct. 747, 21 L.Ed.2d 718; *Campbell v. Beto*, 5 Cir. 1972, 460 F.2d 765; *Landman v. Royster*, E.D.Va.1971, 333 F.Supp. 621; *Holt v. Sarver*, E.D.Ark.1970, 309 F.Supp. 362, *aff'd*, 8 Cir. 1971, 442 F.2d 304. This Court has recognized that 'our constitutional duties require that the courts be ever vigilant to assure that the conditions of incarceration do not overstep the bounds of federal constitutional limitations'. *Campbell*, 460 F.2d at 767-768. In discharging these duties, the federal courts have in some cases entered decrees requiring substantial restructuring of state prison systems, but the courts have not hesitated to enter such decrees when necessary to safeguard the constitutional rights of prisoners. As the court said in *Holt v. Sarver*:

> Let there be no mistake in the matter; the obligation of the Respondents to eliminate existing unconstitutionalities does not depend upon what the Legislature may do, or upon what the Governor may do, or, indeed, upon what Respondents may actually be able to accomplish. If Arkansas is going to operate a Penitentiary System, it is going to have to be a system that is countenanced by the Constitution of the United States.

309 F.Supp. at 385.

Similar developments have occurred in the field of institutions for the detention of juveniles. *Nelson v. Heyne*, 7 Cir. 1974, 491 F.2d 352, *aff'g*, N.D.Ind.1972, 355 F.Supp. 451; *Martarella v. Kelley*, S.D.N.Y.1972, 359 F.Supp. 479, *enforcing*, 349 F.Supp. 575; *Inmates of Boys' Training School v. Affleck*, D.R.I.1972, 346 F.Supp. 1354; *Morales v. Turman*, E.D.Tex.1973, 364 F.Supp. 166.

The appellants' fifth contention, that the plaintiffs had adequate remedies at law, is also unpersuasive. In the *Burnham* case, the court held that the legal remedies of 'habeas corpus, medical malpractice, and ordinary tort actions' would supply adequate remedies to mental patients who claimed to have been denied a right to treatment. 349 F.Supp. at 1343. It found the plaintiffs' arguments to the contrary 'inconsistent with plaintiffs argument that each individual patient should have his particular therapy or treatment personalized'. *Id.* Governor Wallace and the Mental Health Board urge here the argument that damage and habeas corpus actions provide adequate legal remedies to the plaintiffs. The [sic] also point to the plaintiffs' argument that treatment must be individualized, and to the tension between that argument and the plaintiffs' insistence that injunctive relief on behalf of the plaintiff class is appropriate in this case.

We are unable to agree that injunctive relief is inappropriate merely because damages or habeas corpus relief may be available to some or all individual plaintiffs. While habeas corpus and tort remedies should play a valuable, indeed essential, role in enforcing the constitutional rights we recognized in *Donaldson*, those remedies are not capable of ensuring what the plaintiffs seek to ensure in this case. In the first place, habeas corpus relief and tort damages are available only after the fact of a failure to provide individual treatment. Here the plaintiffs seek preventive relief, to assure in advance that mental patients will at least have the chance to receive adequate treatment by proscribing the maintenance of conditions that foredoom all mental patients inevitably to inadequate mental treatment. Moreover, there are special

reasons why reliance upon individual suits by mental patients would be especially inappropriate. Mental patients are particularly unlikely to be aware of their legal rights. They are likely to have especially limited access to legal assistance. Individual suits may be protracted and expensive, and individual mental patients may therefore be deterred from bringing them. And individual suits may produce distortive therapeutic effects within an institution, since a staff may tend to give especially good – or especially harsh – treatment to patients the staff expects or knows to be litigious.[9]

We see no inconsistency between this conclusion and the position taken by the plaintiffs, and by the district court, that treatment must be individualized. The plaintiffs here do not seek to guarantee that all patients will receive all the treatment they need or that may be appropriate to them. They seek only to ensure that conditions in the state institutions will be such that the patients confined there will have a chance to receive adequate treatment. This requires only the establishment of a program, institution-wide in scope, for developing and formulating individual treatment plans; it of course does not require the formulation, in this suit, of each individual plan. The question of what is necessary to the establishment of such a program is better resolved in a class action brought on behalf of all patients than it would be in a series of individual suits.

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[9] See 86 Harv.L.Rev. 1282, 1305 (1973).

IV.

We pretermit decision as to the remedy decreed by the district court to the extent herein stated. As we have held, the legislative power may not be used to deprive appellees of their constitutional right to treatment, but a substantial question is presented as to the scope of judicial power in implementing this right. The ultimate question will be, if all else fails, the method of effecting the financial outlay which will be necessary for the judiciary to give meaning to judicially precribed minimum constitutional standards for adequate treatment of the mentally ill.

Prior to the entry of the court's orders on April 13, 1972, 344 F.Supp. 373; 344 F.Supp. 387, the parties and amici stipulated to a number of specific conditions they agreed were necessary for a constitutionally acceptable minimum treatment program.[10] Because of these stipulations, we need not and do not reach decision as to whether the standards prescribed by the district court are constitutionally minimum requirements, or whether it is within the province of a federal district court, three-judge

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[10] The parties and amici submitted in two Memoranda of Agreement stipulations of standards of adequate care. Virtually all of the specifics of the district court's April 13, 1972 orders were taken from these stipulations. These standards have not been challenged on appeal. Indeed, Governor Wallace's brief to this court begins with the affirmation: 'We wish to emphasize at the outset that this appellant, Governor George C. Wallace, is in full and complete agreement with the ultimate achievement of the standards and goals for mental health facilities which are set forth in the District Court's order(s) of April 13, 1972.' Brief of Appellant, p. 1.

or single judge, to prescribe standards as distinguished from enjoining the operation of such institutions while constitutional rights are being violated.

Governor Wallace contends such stipulations are not binding on him or the Alabama legislature. As a party to the stipulations, through counsel, we hold the Governor has for his part agreed that these standards are minimally acceptable under the Constitution. The Alabama legislature presents a different problem. Clearly the Governor is without authority to agree to the expenditure of funds required to implement such a broad spectrum of standards when such a decision under Alabama law is reserved to the legislature. That the legislature was not a party to the stipulations in question or to this law suit reenforces this manifest principle of governmental organization. It is the Governor's role to propose relief to the legislature and, having stipulated the standards, to use his best efforts to accomplish the relief.

With respect to judicial accomplishment of the remedy, profound questions are presented regarding the scope of substantive due process and the role of federal courts in matters affecting the management of state institutions. Here we are concerned with the operation of state mental institutions within the parameters of substantive due process.[11]

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[11] As noted, supra, however rare they may be, federal decrees mandating affirmative action expenditures by state governing authorities to ensure constitutional guarantees are not unprecedented in cases involving equal protection and also cruel and unusual punishment. E.g., *Griffin v. County School Bd.*, 1964, 377 U.S. 218, 233, 84 S.Ct. 1226, 12 L.Ed.2d 256, 266; *Swann*

The governor argues that the prescribed remedy will entail the expenditure annually of a sum equal to sixty per cent of the state budget excluding school financing, and a capital improvements outlay of $75,000,000. This is contested by appellees. However that may be, we regard as premature any issue as to whether the district court should appoint a Special Master for the purposes of selling or encumbering state lands to finance these standards, or should enjoin certain state officials from authorizing expenditures for nonessential state functions, and thereby alter the state budget, or by other means order a particular mode of financing the implementation of the stipulated standards.

Such remedial propositions are by the terms of the district court's April 13, 1972 not present orders; they lie in the uncertain future. The district court wrote:

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v. Charlotte-Mecklenburg Md. of Educ., N.D.N.C., 1970, 311 F.Supp. 265, 268, *vacated and remanded on other grounds*, 4 Cir. (en banc), 431 F.2d 138, *order reinstated*, 1971, 402 U.S. 1, 91 S.Ct. 1267, 28 L.Ed.2d 554; *United States v. Plaquemines Parish School Bd.*, E.D.La., 1967, 291 F.Supp. 841, *aff'd as modified*, 5 Cir., 1969, 415 F.2d 817; *Cruz v. Beto*, 1972, 405 U.S. 319, 92 S.Ct. 1079, 31 L.Ed.2d 263; *Holt v. Sarver*, 8 Cir., 1971, 442 F.2d 304; *Nelson v. Heyne*, 7 Cir., 1974, 491 F.2d 352; *Gautreaux v. Chicago Housing Auth.*, N.D.Ill., 1969, 296 F.Supp. 907, *aff'd*, 7 Cir., 1970, 436 F.2d 306, *cert. denied*, 1971, 402 U.S. 922, 91 S.Ct. 1378, 28 L.Ed.2d 661.

See also cases cited Note, Right To Treatment, 1973, 86 Harv.L.Rev. 1282, 1300, nn. 98-104; Development in the Law, Civil Commitment of the Mentally Ill, 1974, 87 Harv.L.Rev. 1338, n. 96; Comment, Enforcement of Judicial Financing Order; Constitutional Rights in Search of a Remedy, 1970 59 Geo.L.J. 393.

' . . . this Court has decided to reserve ruling also upon plaintiffs' motion that defendant Mental Health Board be directed to sell or encumber portions of its land holdings in order to raise funds. Similarly, this Court will reserve ruling on plaintiffs' motion seeking an injunction against the treasurer and the comptroller of the State authorizing expenditures for nonessential State functions, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to the implementation of this order. . . . The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, to a lesser degree, upon the defendant Mental Health Board of Alabama. For the present time, the Court will defer to those bodies in hopes that they will proceed with the realization and understanding that what is involved in this case is not representative of ordinary governmental functions such as paving roads and maintaining buildings. Rather, what is so inextricably intertwined with how the Legislature and Mental Health Board respond to the revelations of this litigation is the very preservation of human life and dignity. . . . In the event, though, that the Legislature fails to satisfy its well-defined constitutional obligation, and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master, to ensure that proper funding is realized and that adequate treatment is available for the mentally ill in Alabama.' 344 F.Supp. at 377-378. See also 344 F.Supp. at 393-394. (These separate orders cover the three institutions involved.)

To the latter statement, the district court added in a footnote, 344 F.Supp. at 378, n. 8:

'The Court understands and appreciates that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various State officials and agencies as additional parties to this litigation, and to utilize other avenues of fund raising.' See also 344 F.Supp. at 394, n. 14.

The district court ordered that defendants file within six months a detailed report on the implementation of the stipulated standards.

The serious constitutional questions presented by federal judicial action ordering the sale of state lands, or altering the state budget, or which may otherwise arise in the problem of financing, in the event the governing authorities fail to move in good faith to ensure what all parties agree are minimal requirements, should not be adjudicated unnecessarily and prematurely. See *Ashwander v. Tennessee Valley Authority*, 1936, 297 U.S. 288, 346-348, 56 S.Ct. 466, 80 L.Ed. 688, 710-712 (Brandeis, J., concurring); cf. *Hawkins v. Town of Shaw*, 5 Cir. (en banc), 1972, 461 F.2d 1171; *Holt v. Sarver*, 8 Cir., 1971, 442 F.2d 304, 309. Since we have now affirmed that part of the district court's orders recognizing the constitutional right to treatment, determination of good faith efforts by state

authorities to ensure these rights should be made in the first instance in the district court.

In any event, as a jurisdictional matter dictated by federal statute, remedies of the type contemplated in the district court order of April 13, 1972 are required to be determined by a district court of three judges. Any federal decree that state lands be sold or legislative appropriations be reallocated or enjoined would involve state laws of statewide significance within the purview of 28 U.S.C.A. 2281. The federal injunctive decree which might be entered in such circumstances is required to be that of a three-judge district court. *Sands v. Wainwright, supra,* 491 F.2d 417. We of course make no prejudgment as to the appropriateness of any such remedial order. Moreover, depending on the improvements made or in progress, such remedies may be unnecessary.

This court views as serious a state's failure to ensure the fulfillment of appellees' constitutional rights, but the interests of all concerned, and the sensitivities of our federal system, will be best served by the parties, amici, and court moving together to meet the constitutional requisites. This is the nature of the remedy ordered by this court in *Hawkins v. Town of Shaw, supra,* 461 F.2d at 1174. This appears to be the meaning and intent of the district court's recognition of the function of the Alabama legislature within the Alabama governmental framework, and the court's orders of April 13, 1972 requiring reports on compliance with the stipulated standards.

This approach should hasten the day when the district court can be reasonably assured that appellees' constitutional rights are no longer being violated, and when

ultimate control over the institutions in question can be returned to the state. *Cf. Holt v. Sarver, supra,* 442 F.2d at 309.

V.

We reserve decision on the issue presented by the awards of attorneys' fees to plaintiffs pending decision in No. 73-1790, *Gates v. Collier;* No. 73-2033, *Newman v. State of Alabama;* and *Named Individual Members of the San Antonio Conservation Society v. Texas Highway Department,* en banc, argued and submitted on October 2, 1974. See 28 U.S.C.A. 2106 for the authority to reserve decision.

Affirmed in part; remanded in part for further proceedings not inconsistent herewith; and decision reserved in part.

IN THE DISTRICT COURT OF THE
UNITED STATES FOR THE
MIDDLE DISTRICT OF ALABAMA,
NORTHERN DIVISION

RICKY WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., et al.,	)	
Plaintiffs,	)	
DIANE MARTIN, et al.,	)	
Plaintiff-Intervenors,	)	CIVIL ACTION NO. 3195-N
v.	)	
R. EMMETT POUNDSTONE, as Commissioner of Mental Health and Mental Retardation, and the State of Alabama Mental Health Officer, et al.,	)	(Filed Oct. 3, 1995)
Defendants,	)	
UNITED STATES OF AMERICA,	)	
Amicus Curiae.	)	

ORDER

In this ongoing lawsuit, the plaintiffs, who are residents of facilities in the Alabama Mental Health and Mental Retardation System, claim that defendant state officials are violating their rights under a 1986 consent decree, the United States Constitution, and the Americans with Disabilities Act, 42 U.S.C.A. §§ 12101-12213 (West

Supp. 1995).[1] Now before the court are two motions filed by the defendants pursuant to Rule 23 of the Federal Rules of Civil Procedure: (1) a motion to recertify or modify the plaintiff class[2] and (2) a supplemental motion to recertify or modify the plaintiff class and alternative motion to decertify the plaintiff class.[3] The court also has before it (3) a motion filed by Robert Hanna, Gregory Wolke, Jean Washington, Brent Bugsch, Benjamin Stokes, Stephanie Ramsey, and Eric Boothe seeking to intervene as plaintiffs pursuant to Rule 24 of the Federal Rules of Civil Procedure.[4] By order entered on March 14, 1995, the court conditionally granted the last motion and allowed the "Hanna plaintiffs" to intervene subject to reconsideration and briefing by the parties.[5]

For the reasons that follow, the defendants' two motions will be granted to the extent they seek recertification of the class, and the court will reaffirm its earlier order granting the Hanna plaintiffs' motion to intervene.

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[1] For purposes of this opinion, the court considers mentally-ill to refer both to individuals with mental-illness and those with an emotional disturbance. However, the court does not reach whether mental illness and emotional disturbance are the same phenomena medically. *See Wyatt v. Hardin*, No. 3195-N (M.D. Ala. Feb. 28, 1975) (defining mentally-ill portion of class as consisting of individuals with mental illness or an emotional disturbance).

[2] Filed December 22, 1994 (Doc. no. 417).

[3] Filed January 18, 1995 (Doc. no. 456).

[4] Filed March 10, 1995 (Doc. no. 702).

[5] Doc. no. 717.

I. BACKGROUND

This lawsuit began in 1970. Although no party has been able to locate in the record a formal order certifying the class, the court and all of the parties have treated this lawsuit as a class action for almost 25 years. *See, e.g., Wyatt v. Stickney,* 344 F. Supp. 373 (M.D. Ala. 1972) (ordering relief as to class of mentally-ill plaintiffs), *aff'd in relevant part,* 503 F.2d 1305 (5th Cir. 1974); *Wyatt v. Stickney,* 344 F. Supp. 387 (M.D. Ala. 1972) (ordering relief as to class of mentally-retarded plaintiffs), *aff'd in relevant part,* 503 F.2d 1305 (5th Cir. 1974); *Wyatt v. Stickney,* No. 3195-N (M.D. Ala. Aug. 12, 1971) (enlarging plaintiff class); *Wyatt v. Hardin,* No. 3195-N (M.D. Ala. Feb. 28, 1975) (enlarging plaintiff class); *Wyatt v. Wallis,* No. 3195-N, 1986 WL 69194 (M.D. Ala. Sept. 22, 1986) (approving proposed consent decree as meeting requirements of Rule 23 regarding class actions); *Wyatt v. Horsley,* No. 3195-N (M.D. Ala. Aug. 3, 1989) (concluding that residents of Kidd facility are subject to *Wyatt* mental-illness standard nine); *Wyatt v. Horsley,* 793 F.Supp. 1053 (M.D. Ala. 1991) (rejecting proposed consent decrees because parties did not meet requirements of Rule 23 regarding class actions); *Wyatt v. Horsley,* 793 F.Supp. 1058 (M.D. Ala. 1992) (approving proposed consent decrees as meeting requirements of Rule 23 regarding class actions).

Because, among other reasons, none of the named class members remain in state institutions under the supervision or control of the Alabama Department of Mental Health and Mental Retardation, the defendants moved for recertification or modification of the class in December 1994 and supplemented this motion by moving

for decertification in January 1995. At a telephone conference held on January 6, 1995, the court expressed its concern over the absence of named class members with live interests in the lawsuit and suggested that new named plaintiffs with live interests intervene.[6] On March 10, 1995, the Hanna plaintiffs moved to intervene. As previously stated, the court conditionally granted the motion subject to reconsideration and briefing by the parties.

II. DISCUSSION

With their two motions, the defendants argue that the plaintiff class in this lawsuit should be decertified, recertified, or modified. They further oppose reaffirmation of intervention by the Hanna plaintiffs. The court agrees with the defendants that the class needs to be recertified to the extent that its parameters need clarification and its named class members' interests have become moot due to the passage of time. The court disagrees, however, that the plaintiff class should be decertified or modified. The

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[6] Counsel for the plaintiffs have questioned defense counsel's motives in waiting until now to challenge the treatment of this litigation as a class action. Plaintiffs' brief filed on February 6, 1995 (Doc. no. 516), at 2-3. The plaintiffs contend that the defendants have not only waited for years to make this challenge, they have done so in the midst of the plaintiffs' extensive trial preparation, adopting what the plaintiffs characterize as "a strategy of diverting as much of plaintiffs' time from trial preparation as possible." *Id.* at 2. Irrespective of the motive behind the defendants' timing, the issue is important and demands immediate attention.

court also concludes that the Hanna plaintiffs should be allowed to continue as parties to this litigation.

A. Decertification

The defendants advance three arguments in support of their contention that the plaintiff class should be immediately decertified.

1. Lack of a Formal Certification Order

The defendants argue that the class should be decertified because there is no formal order of certification. Where a lawsuit has proceeded to trial as a class action, the class has been clearly defined and redefined over the years, injunctive relief has been ordered as to the class, all parties and the court have treated the lawsuit as a class action, and for over 20 years no party has suggested that certification was an issue, as is all true in this lawsuit, the case is for all intents and purposes a class action even though no formal certification order has been entered, and neither certification, recertification, nor decertification is required. As the former Fifth Circuit Court of Appeals wrote in *Graves v. Walton County Bd. of Educ.*, 686 F.2d 1135, 1139-40 (1982) (Unit B), "despite the lack of a formal order certifying this case as a class suit, this case was in fact a class action and was specifically described and treated as such by the parties and the trial court. . . . [T]he district court's implicit determination of the class action question sufficed in a suit in which all the parties and the court proceeded off the assumption that the action was a class action, despite the fact that there existed no formal order of certification by the district

court."[7] *See also Lockett v. Board of Educ.*, 976 F.2d 648, 649 (11th Cir. 1992) (per curiam) (reaffirming *Graves*); *Johnson v. General Motors Corp.*, 598 F.2d 432, 435 (5th Cir. 1979) (class action may exist in absence of formal certification order if litigation was conducted as class action); *Bing v. Roadway Express, Inc.*, 485 F.2d 441, 447 (5th Cir. 1973) (same); *Cf. Vaughter v. Eastern Air Lines, Inc.*, 817 F.2d 685, 689 (11th Cir. 1987) (failure to designate class in judgment may be corrected where lawsuit has been maintained and treated as a class action).[8] Here, the lack of a formal order certifying a plaintiff class does not require decertification.

2. Mootness

The defendants contend that decertification is required because of mootness of the former named plaintiffs' claims. Where the court is confronted with named plaintiffs who no longer have live interests, the appropriate course is to substitute new named class members. Again, as the appellate court stated in *Graves*, "It is firmly established that where a class action exists, members of the class may intervene or be substituted as named plaintiffs in order to keep the action alive after the claims of

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[7] In *Stein v. Reynolds Securities, Inc.*, 667 F.2d 33, 34 (11th Cir. 1982), the Eleventh Circuit Court of Appeals adopted as binding precedent all of the post-September 30, 1981, decisions of Unit B of the former Fifth Circuit.

[8] In *Bonner v. Prichard*, 661 F.2d 1206, 1209 (11th Cir. 1981) (en banc), the Eleventh Circuit adopted as binding precedent all of the decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981.

the original named plaintiffs are rendered moot." 686 F.2d at 1138.

3. Class Conflict

The defendants contend that the class should be immediately decertified because of a conflict of interest within the plaintiff class. The defendants argue that the class is divided between those who advocate community placement of residents and those who oppose it. The defendants' argument lacks merit.

i.

It appears that any conflict within the plaintiff class may have resulted at least in large part from misinformation disseminated by the defendants. The defendants have sent letters to class members, their guardians, caregivers, and next-of-kin informing them that the plaintiffs and their attorneys are seeking to have services for all class members reduced and full deinstitutionalization of the mentally-retarded, that is, to have all mentally-retarded class members now residing in the defendants' developmental centers moved into the community. The defendants failed to state in their letters that the plaintiffs advocate that the defendants be required to develop more extensive and greater community services and that institutionalized residents be given the choice between institutionalization and community placement. With this omission, the defendants left the important misimpression that the plaintiffs

seek to close the state's facilities and force patients out without any support services.[9]

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[9] The defendants sent a letter to guardians of mentally-retarded residents in the state's developmental centers stating:

> "This letter shall serve as notice that the Department of Mental Health and Mental Retardation is currently involved in a lawsuit involving your ward, [name], at the [name] Developmental Center. The plaintiffs' attorneys in this lawsuit claim to represent your ward. One of the Plaintiffs' objectives in this case is to close the state's mental retardation facilities, including [name] Developmental Center."

Plaintiffs' brief filed on February 6, 1995 (Doc. no. 516) (exh. C). The defendants failed to add that the plaintiffs advocate the development of more extensive and greater community services and want to give institutionalized residents the choice, where appropriate, between institutionalization and community placement.

Other letters were sent to family members and guardians of class members, including the mentally-ill patients, stating:

> "This letter shall serve as notice that the Department of Mental Health and Mental Retardation is currently involved in a lawsuit involving your ward/relative at [name of institution]. The Plaintiffs' attorneys in this lawsuit claim to represent your ward/relative as counsel for the Plaintiff's class members. One of the Plaintiffs' objectives in this case is to substantially reduce the state's mental health facilities."

Plaintiffs' brief filed on February 6, 1995 (Doc. no. 516) (exh. D). Again, with their omission, the defendants presented a false picture of the plaintiffs' position in this litigation.

To acquiesce to the defendants' contention and conclude that the plaintiff class is in conflict and due to be decertified, when that conflict may have largely resulted from misinformation spread by the defendants, would not only be illogical, it would be manifestly unjust. Also, because of the dissemination of this misinformation, it is now almost impossible to determine at this time the degree and nature, if any, of true conflict within the class. In any event, the remedy for the so-called conflict at this point should be to provide the class with correct information and continually to reevaluate any expressions of conflict within the class.

The court emphasizes that, although it appears that the defendants may have misinformed the plaintiff class regarding the named plaintiffs' contentions in this litigation, the court should not be understood to have agreed that these contentions have legal merit. As will be explained later, the legal merit, if any, in the named plaintiffs' contentions are not before the court at this time. Nor should the court be understood to imply that the defendants may not themselves express to the public, including class members and their representatives, the

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These letters went on to state that the Department was objecting to producing class members' records to plaintiffs' attorneys and encouraged the guardian or family member to contact the Department if he or she objected to counsel having access to their ward's records. These letters were sent to guardians after the Magistrate Judge specifically cautioned the defendants not to "encourage" plaintiffs and their guardians to object to producing the class members' records without explicit approval of the district court – approval which was not obtained. Transcript of July 21, 1994 proceedings before United States Magistrate Judge McPherson at 69.

defendants' views on how this litigation should proceed. Indeed, irrespective of the outcome of the issues now before this court, open and public debate of these issues among all concerned can only be healthy.

ii.

In addition, the fact that there are some plaintiff class members who, though correctly informed of the named plaintiffs' position on community placement in this litigation, still do not agree with it, does not necessarily warrant decertification at this point. First of all, in large and complex litigation such as this one, potentially involving thousands of class members and scores of legal issues, many of them convoluted and difficult, it would be impossible to obtain and maintain 100% agreement within the class as to all matters. To impose such a requirement would, in effect, preclude the use of the class action device in many of the very cases that it could be most advantageous.

Therefore, the question should not be whether there is a 100% concurrence of interests within the class but rather whether the class as a whole and as to some primary issues being litigated is being adequately represented. Rule 23 "does not require that *all* questions of fact and law be common, but only demands that a question of law *or* fact be presented which is shared in the grievances of the prospective class as defined." 3B James W. Moore et al., Moore's Federal Practice ¶ 23.06-1 at 23-159 (2d ed. 1995). *See also Weiss v. York Hospital*, 745 F.2d 786 (3rd Cir. 1984), *cert. denied*, 470 U.S. 1060, 105 S.Ct. 1777 (1985); *Ventura v. New York City*, 125 F.R.D. 595 (S.D.N.Y. 1989);

Wilcox v. Petit, 117 F.R.D. 314, 317 (D.Me. 1987); *In re Gulf Oil/Cities Serv. Tender Offer Litigation*, 112 F.R.D. 383 (S.D.N.Y. 1986). The issue of community placement is only one of many important, complex and difficult issues confronting the court. Although class certification may not be proper when the class includes "members who disagree about the propriety of relief" generally, *Miles v. Metropolitan Dade County*, 916 F.2d 1528 (11th Cir. 1990), the fact that there may be class members who disagree with the named class on one issue does not warrant dispensing with the utility of the class device as to all other important issues. *See Horton v. Goose Creek Ind. Sch. Dist.*, 690 F.2d 470, 487 (5th Cir. 1982) (value of class action device and availability of corrective procedures outweighs danger of antagonism within class), *cert. denied*, 463 U.S. 1207, 103 S.Ct. 3536 (1983).

Moreover, there are many procedural safeguards available under the Federal Rules of Civil Procedure that can be brought into play if a clear conflict develops. *See Social Services U., Local 535 v. Cty. of Santa Clara*, 609 F.2d 944, 948 (9th Cir. 1979) ("If at any time before, during, or after trial it appears that . . . [the representatives] no longer fairly and adequately protect the interests of the class. . . . [o]ne or more of the many available procedural safeguards can be brought into play to protect the absentees"). For example, Rule 23(c)(4) allows for certification of a class "with respect to particular issues." Therefore, if a class member differs with how the named plaintiffs are pursuing a particular issue and wishes to pursue that issue as a representative of a subclass, that member may seek to intervene to represent a subclass as to that issue. No class member has sought intervention to

represent the class, or a subclass, as to an issue at this point.[10] The court would certainly consider such a motion if it were brought and might even initiate the formation of a subclass on a specific issue if it appeared necessary to assure adequate representation of plaintiffs.

Finally, decertification is not warranted at this time because it appears that the position of those class members who might oppose named plaintiffs on community placement issues is already being adequately – indeed, aggressively – advanced in this litigation by the defendants. *See Horton*, 690 F.2d at 487 (although some plaintiff class members approved of school drug searches in case challenging the searches' constitutionality, class was appropriate where approving students' interests were aggressively represented by defending school district); *Dierks v. Thompson*, 414 F.2d 453, 457 (1st Cir. 1969) (although not all plaintiff class members agreed with every goal pursued by named plaintiffs, plaintiff class was appropriate because the interest of the disagreeing

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[10] Admittedly, William Edward Haas sought to intervene in this cause as next friend and legal guardian of his daughter, a mentally incompetent woman who is now a resident of one of the state's institutions for the mentally retarded and mentally ill. He took issue with how the named plaintiffs were pursuing certain issues. The court rejected Haas's effort because he wanted to pursue only individual relief on behalf of his daughter and not class relief as to these issues. *Wyatt v. Hanan*, No. 3195-N (M.D. Ala. Feb. 15, 1995). The court explained that to allow all guardians and other similar representatives to intervene to pursue only individual relief "would render this lawsuit more unmanageable and unnecessarily confusing than it already is." *Id.* at 11.

plaintiffs was adequately represented by defendants in the litigation).[11]

Of course, if the defendants were to abandon their strong opposition to the named plaintiffs' position in this litigation, and if it appeared that there was still credible opposition within the plaintiff class to the named plaintiffs' position, the court would seriously have to consider taking measures to assure that opposition from within the class was being adequately addressed in the litigation. The consideration of the views of class members opposed to positions taken by the named plaintiffs and their counsel would not be new to this litigation. In 1991, the court sustained an objection from parts of the plaintiff class to several proposed consent decrees even though the decrees had the support of counsel for both plaintiffs and defendants. *Wyatt v. Horsley*, 793 F.Supp. 1053, 1056 (M.D. Ala. 1991).

B. Modification or Recertification

The defendants argue, in the alternative, that the class should be modified or recertified. They request that the court do the following: appoint new class representatives and new class counsel; explicitly state who is in the class; clarify whether this is a Rule 23(b)(2) or (b)(3) class action; permit the plaintiffs to opt out of the class pursuant to Rule 23(b)(3) if they wish; and issue notice to

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[11] The court similarly found with regard to Haas, *see supra* note 10, that his intervention was not necessary because the issues he sought to pursue were already being adequately pursued in the litigation. *Wyatt v. Hanan*, No. 3195-N (M.D. Ala. Feb. 15, 1995), at 9-10.

class members pursuant to Rule 23(d)(2). The court agrees that the class should be recertified to the extent that its parameters should be clarified and new named representatives, with live interests, brought in to represent the class. The court concludes that current class counsel are providing excellent representation to the plaintiff class and that to appoint new class counsel would be pointless and, more than likely, hurt the class's interests. The court further concludes that this lawsuit is a Rule 23(b)(2) class action. As to notice, the court will require that the parties establish procedures for providing regular notice to the class and for allowing plaintiffs' counsel regular access to class members.

In order to represent a class of allegedly similarly situated individuals, the proposed named plaintiffs must demonstrate that "(1) the class is so numerous that joinder of all members is impracticable, (2) there are questions of law or fact common to the class, (3) the claims or defenses of the representative parties are typical of the claims or defenses of the class, and (4) the representative parties will fairly and adequately protect the interests of the class." Fed.R.Civ.P. 23(a). Additionally, a class must meet one of three conditions stated in Rule 23(b) which make a class action the preferable mode of handling the lawsuit. If the four requirements of Rule 23(a) and one of the conditions of Rule 23(b) are met, then the class may be certified. *See General Telephone Co. of Southwest v. Falcon*, 457 U.S. 147, 156, 102 S.Ct. 2364, 2370 (1982).

Before addressing these five criteria, however, the court examines the parameters of the class that is to be recertified because the parties are not in agreement over its exact contours.

1. Class Definition

The parties are in agreement over the definition of the mentally-retarded portion of the class, but disagree over who comprises the mentally-ill portion of the class. The mentally-retarded portion of the class consists of all mentally-retarded residents who live in the Alabama Department of Mental Health and Mental Retardation's developmental centers, or any home or facility, public or private, to which an individual has been assigned or transferred to by the Department.[12] The parties' disagreement as to the mentally-ill portion of the class is over whether this class consists of only involuntarily committed or both voluntarily and involuntarily committed patients who reside in the Department's hospitals, or any other centers, homes, or facilities, public or private, to which an individual is assigned or transferred for residence by the Department. The defendants contend that the *Wyatt* orders and the law apply only to involuntarily committed mentally-ill patients and do not apply to the voluntarily committed.

The plaintiffs correctly observe that the parties and the court have historically treated the voluntarily-committed mentally-ill patients as part of the class. The class originally consisted of mentally-ill patients at Bryce Hospital. In 1971, the court expanded the class to include mentally-ill patients at Searcy Hospital and mentally-retarded residents at the Partlow State School and Hospital. *Wyatt v. Stickney,* No. 3195-N (M.D. Ala. Aug.

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[12] *See Wyatt v. Hardin,* No. 3195-N (M.D. Ala. Feb. 28, 1975) (expanding and defining class); court's exh. 2 (agreed upon standards for mentally-retarded class members).

12, 1971). In 1975, the court held that it was "necessary and proper to extend to all facilities in which the mentally ill and emotionally disturbed are cared for and treated by the state the minimal constitutional standards for adequate treatment of the mentally ill which ha[d] previously been established for Bryce and Searcy Hospitals." *Wyatt v. Hardin*, No. 3195-N (M.D. Ala. Feb. 28, 1975). Thus, the court expanded the class to include *all* mentally-ill patients at any facility or hospital operated by the Department. This has been repeatedly interpreted by the court and parties to include voluntarily and involuntarily committed patients. For example, in 1989 the court required the parties to adhere to the *Wyatt* standards regarding electro-convulsive treatment at its Kidd facility. *Wyatt*, No. 3195-N (M.D. Ala. Aug. 3, 1989). The patients at the Kidd facility are predominantly geriatric patients and many, if not all, are considered by the defendants to be "voluntarily committed" patients. As previously indicated, when the parties and court have treated a group as a class and ordered relief as to that group as a class, they are, in fact, a class, even in the absence of a formal certification order. *See Graves*, 686 F.2d at 1136-40; *Johnson*, 598 F.2d at 435; *Bing*, 485 F.2d at 447.[13]

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[13] The court notes that many "voluntary" patients are not exactly voluntary. To be a voluntary patient, an individual must be able to leave the institution if he or she so desires. "To the extent that patients might be prevented from leaving," whether they entered voluntarily or not, "they become involuntary patients." *Doe v. Public Health Trust of Dade County*, 696 F.2d 901, 903 n.10 (11th Cir. 1983) (per curiam). For example, the status of many patients who are admitted as involuntary civil commitments is nominally changed to "voluntary" when the patient no longer meets the criteria for commitment, but the

The defendants respond that a 1992 order by this court approving several consent decrees superseded prior definitions of the class and narrowed the mentally-ill portion of the class to include only involuntarily committed patients. *Wyatt v. King*, 793 F. Supp. 1058 (M.D. Ala. 1992). The plaintiffs counter that the intent behind the change in certain definitions was to clarify that "that the standards for treatment of people with mental illness apply not only to 'hospitals' but to all state-operated 'facilities,' " *id.* at 1063, and it was not to redefine the class to exclude the voluntarily committed. The plaintiffs note that at no time during the Rule 23 approval process of the decrees was the impact of the decrees on the interests of voluntarily committed patients considered by the parties or, more importantly, by the court in making its required determination that the decrees were "fair, adequate and reasonable" as to the class. *Id.* at 1061.

Whether voluntarily committed patients are due relief in this lawsuit is not, however, an issue for resolution at this time. The definition of the class for certification purposes is a procedural question distinct from the merits of the lawsuit. "[T]he question is not whether the plaintiff or plaintiffs . . . will prevail on the merits, but rather whether the requirements of Rule 23 are met."

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defendants are unable to find a suitable community placement. Additionally, the majority of patients who reside at the Kidd, Allen, and Box nursing facilities are incompetent. The admission and continued stay of an incompetent individual in a locked facility cannot be considered voluntary in any true sense of the word. *See, e.g., Zinermon v. Burch*, 494 U.S. 113, 133-34, 110 S.Ct. 975, 987-88 (1990); *Doe v. Austin*, 848 F.2d 1386, 1392 (6th Cir.), *cert. denied*, 488 U.S. 967, 109 S.Ct. 495 (1988).

Eisen v. Carlisle & Jacqelin, 417 U.S. 156, 178, 94 S.Ct. 2140, 2153 (1974); *see also Love v. Turlington*, 733 F.2d 1562, 1565 (11th Cir. 1984); *Jordan v. Swindall*, 105 F.R.D. 45, 46-47 (M.D. Ala. 1985). Therefore, the question before the court is not whether the plaintiffs, voluntarily or involuntarily committed patients, will prevail or be entitled to relief, but whether the requirements of Rule 23 are met – that is, whether the proposed class of plaintiffs, both the voluntarily and involuntarily committed, meet the numerosity, commonality, typicality, and representativeness requirements of Rule 23. Indeed, if together they do, it is essential that the interests of the voluntarily committed be adequately represented in this litigation when the court does ultimately reach the issue of whether the 1992 consent decrees narrowed the reach of the *Wyatt* mental-illness standards to apply to only the involuntarily committed.

2. Numerosity

The numerosity requirement of Rule 23(a)(1) is satisfied if joinder of all plaintiff class members would be impracticable. In this case the class is so numerous that joinder is impracticable. There are approximately 1,000 mentally-retarded individuals in the defendants' institutions and well over 1,000 mentally-ill patients in their institutions. This requirement is therefore met.

3. Commonality and Typicality

Rule 23(a)(2) & (3)'s requirements of commonality and typicality "tend to merge." *Falcon*, 457 U.S. at 157

n.13, 102 S.Ct. at 2370 n.13. Both requirements serve to ensure that the "maintenance of a class action is economical" and that "the named plaintiff's claim and the class claims are so interrelated that the interests of the class members will be fairly and adequately protected in their absence." *Id.*

These requirements are also met. The named plaintiffs share multiple interests and claims identical to the class members' claims. The mentally-ill named plaintiffs claim, among other things, that they do not receive adequate treatment, that their safety is threatened, and that, if appropriate, they would like to live in the community. For example, several of the named class members contend that there is no reason for their continued institutionalization other than a lack of community services. One also alleges that when he has been released in the past, he has not received adequate transitional and community care. The mentally-retarded named plaintiffs claim, among other things, that they are denied a safe environment and, in fact, have been physically abused while in the defendants' care. They also claim that they receive inadequate habilitation and have been denied the opportunities to reach their potential because the defendants have not given them an informed choice to live in the community. These claims are all common to and typical of the class.

4. Adequate Representation

The adequacy inquiry is two-fold. First, the court must assure itself that the named representative will adequately and diligently represent the class members'

interests and that no potential conflicts in interest will interfere with this representation. Due process requires this. *Hansberry v. Lee*, 311 U.S. 32, 42-43, 61 S.Ct. 115, 118-19 (1940). Second, the court must determine that the class's attorneys will adequately represent the class's interests.

The inquiry into the adequacy of the named representative tends to merge with the commonality and typicality requirements, because the extent of the identity of interests bears on the adequacy of the representative. *See Nelson v. United States Steel Corp.*, 709 F.2d 675, 679 n.10 (11th Cir. 1983); *Wynn v. Dixieland Food Stores, Inc.*, 125 F.R.D. 696, 700 (M.D. Ala. 1989). As discussed previously, if a group of persons has suffered injuries at the hands of the same policy or action, then they have a commonality of interests. The plaintiffs' claims therefore are coextensive with the class as a whole. In addition to the coextensiveness of interests, several other factors are relevant to the adequacy of representation issue: whether the named members' interests are antagonistic in any way to the interests of those whom they seek to represent, the proportion of those made parties to the total class membership, and any other facts bearing on the ability of the named party to speak for the rest of the class. *Jordan*, 105 F.R.D. at 48. The court finds that these additional factors all weigh in favor of certification. As explained earlier in rejecting the defendants' motion for decertification, there are no apparent conflicts of interest that warrant rejection of class certification. Although the class is very large, there are enough named plaintiffs to enable adequate representation. And finally, the named plaintiffs are effective representatives. The mentally ill plaintiffs were all

able to speak eloquently and forcefully at trial about their experiences on behalf of the members of the class. The mentally-retarded plaintiffs both have very active parents who were able to speak for them at trial. These factors strengthen the proposed named plaintiffs' ability to represent the plaintiff class. The named plaintiffs are adequate representatives of the class.

There can be no question that class counsel have provided excellent representation and zealous advocacy to their clients. They secured a preliminary injunction regarding conditions of safety for children at the Eufaula Adolescent Center, *Wyatt v. Poundstone*, 892 F.Supp. 1410 (M.D. Ala. 1995); negotiated improvements to the *Wyatt* standards, *e.g.*, *Wyatt v. Poundstone*, No. 3195-N, 1995 WL 430939 (M.D. Ala. July 11, 1995); *Wyatt v. King*, 793 F. Supp. 1058 (M.D. Ala. 1992); defeated the defendants' efforts to vacate important and crucial *Wyatt* standards, *Wyatt v. King*, 803 F.Supp. 377 (M.D. Ala. 1992); *Wyatt v. King*, 811 F.Supp. 1533 (M.D. Ala. 1993); and have assembled an able team of lawyers to defend the plaintiffs' interests.

Nevertheless, the defendants contend that the plaintiffs' attorneys have not been adequate class representatives because they examined clients' records without first obtaining the guardians' permission. However, both the United States Magistrate Judge and this court upheld plaintiffs' counsel's right to do so. The defendants contend that the plaintiffs' counsel were negligent for not issuing a notice to all class members and their families and guardians concerning the status of the case. However, the plaintiffs' counsel must rely on the defendants to post their notices in state facilities and to provide the

names and addresses of all guardians, next-of-kin, and caregivers. This has been a point of deep conflict between counsel for plaintiffs and counsel for the defendants, and to the extent that the plaintiff class has received inadequate notice, the defendants are not blameless. Plaintiffs' counsel's failure to communicate effectively with the class is not a basis for a finding of inadequate representation as this time. In any event, the issue of notice is addressed later in this order.

Finally, borrowing language from an earlier opinion in which the court refused to approve a proposed consent decree submitted by both plaintiffs and defendants, the defendants contend that class counsel has become " 'the *dominus litus,*' that is, the true master of the lawsuit." *Wyatt v. Horsley,* 793 F.Supp. 1053, 1056 (M.D. Ala. 1991). In that opinion, the court did not say that the plaintiffs' counsel had become the master in this litigation, but rather cautioned all parties (both plaintiffs and defendants) that this was a risk unless, "to the extent plaintiffs' counsel cannot receive input from class members, he . . . seek[s] it from such secondary sources as public interest organizations, former mental patients, and family members and caregivers who have day-to-day contact with class members in the state's institutions." *Id.* The court recognized the "difficulties class counsel faces in endeavoring to solicit the views of . . . persons" who "are unlikely to be able to . . . voice their comments." *Id.* The plaintiffs' counsel heeded this caution, and counsel for both the plaintiffs and defendants subsequently submitted a new proposed decree which was approved by the court. *Wyatt v. King,* 793 F.Supp. 1058 (M.D. Ala. 1992).

The attorneys from the Bazelon Mental Health Center have been representing the plaintiff class for several years, and the lead attorney, Mr. Ira Burnim, has been representing the plaintiffs since at least October 1982. The court has thus had a great deal of time and many opportunities to observe plaintiffs' attorneys and to assess their representation of the plaintiff class. It is no easy task to represent such a plaintiff class in a lawsuit that has been ongoing for so many years and in which there are multiple and complex legal issues. It is also quite difficult to represent a class of plaintiffs who are unlikely to be able to "voice" their interests themselves. *Wyatt*, 793 F. Supp. at 1056. Yet, as this court has previously noted, counsel for the plaintiff class, Mr. Ira Burnim, "is to be strongly commended for the sensitive and effective manner" in which he has represented the plaintiff class, *Wyatt*, 793 F. Supp. at 1062 n.7.

The defendants further contend that the named plaintiffs and plaintiffs' counsel are not adequate because of a conflict of interest. The court has already rejected this contention. The court therefore finds the defendants' allegations of inadequate representation to be baseless.

5. Rule 23(b)(2) or (b)(3) Class

The plaintiffs contend that the class should be certified under Rule 23(b)(2), which is appropriate when "the party opposing the class has acted or refused to act on grounds generally applicable to the class, thereby making appropriate final injunctive relief or corresponding declaratory relief with respect to the class as a whole." The defendants contend that the class should be certified,

if at all, under Rule 23(b)(3), which is appropriate when the court find "that the questions of law or fact common to the members of the class predominate over any questions affecting only individual members, and that a class action is superior to other available methods for the fair and efficient adjudication of the controversy." Under Rule 23(b)(3), notice must be sent to all class members and they must be given the opportunity to opt in or opt out of the class. Fed.R.Civ.P. 23(c)(2).

The court disagrees with the defendants. In this lawsuit, Rule 23(b)(2) is more applicable to the class. The defendants have acted on grounds generally applicable to the class, "thereby making appropriate final injunctive or corresponding declaratory relief with respect to the class as a whole." Fed.R.Civ.P. 23(b)(2). As the commentary to Rule 23 states, subdivision (b)(2) is generally applicable to civil-rights lawsuits, although it is not limited to them. Subdivision (b)(3) is meant to apply to situations where a class action is "not clearly called for" by subdivisions (b)(1) or (b)(2). Because subdivision (b)(2) applies, the court need not apply subdivision (b)(3). *See Bing v. Roadway Express, Inc.*, 485 F.2d 441, 447 (5th Cir. 1973) (Rule 23(b)(2) actions are generally preferred over (b)(3) actions where (b)(2) is applicable).

For the reasons stated above, the plaintiff class should be recertified pursuant to Rule 23(a) & (b)(2) of the Federal Rules of Civil Procedure as a class of mentally-ill and mentally-retarded individuals who live in hospitals, centers, facilities, or homes, public or private, to which the individual has been assigned or transferred to by the Department.

C. Notice to and Contact with the Plaintiff Class

Because the plaintiff class will be recertified pursuant to Rule 23(a) & (b)(2), notice need not be sent to class members and class members need not be given the opportunity to opt out. However, counsel for both plaintiffs and defendants agree that notice should be given to class members regarding issues in and the status of this litigation. In addition, the court believes that, in light of past conflicts between counsel for defendants and counsel for plaintiffs over access to members of the plaintiff class, a structure should be established in which plaintiffs' counsel could have regular and adequate access to the plaintiff class. The court will therefore require that the United States Magistrate Judge, with input from counsel for both plaintiffs and defendants, fashion the following within 45 days:

A procedure by which plaintiffs' counsel may give the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys) immediate notice of the issues in and status of this litigation.

A procedure which will allow plaintiffs' counsel to give to the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys) regular and adequate notice of the issues in and status of this litigation.

A procedure by which plaintiffs' counsel may have regular and adequate access to the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys).

D. Intervention

For the reasons previously stated, the Hanna plaintiffs' motion to intervene should be granted. Rule 24 of the Federal Rules of Procedure governs intervention. A party may intervene as of right or with permission of the court. Under subsection (a)(2) to Rule 24, a party seeking to intervene as a matter of right must meet the following requirements: (1) the application must be timely; (2) the interest asserted must relate to the property or transaction that is the subject of the action; (3) the applicant must be situated such that disposition of the action may impede or impair the applicant's ability to protect that interest; and (4) the interest asserted must be represented inadequately by the existing parties to the lawsuit. *Chiles v. Thornburg*, 865 F.2d 1197, 1213 (11th Cir. 1989).[14] If these four requirements are all met, intervention must be granted. *Id.* at 1213. These four requirements are all met for the same reasons the court has stated that recertification is appropriate.

Intervention is also appropriate as a matter of discretion. Under Rule 24(b)(2), a court has discretion to allow

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[14] Subsection (a)(2) to Rule 24 provides:

> "Upon timely application anyone shall be permitted to intervene in an action: . . . when the applicant claims an interest relating to the property or transaction which is the subject of the action and the applicant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest, unless the applicant's interest is adequately represented by existing parties."

intervention if an applicant can show that (1) the application to intervene is timely and (2) the claim or defense to be asserted and the main action have a question of law or fact in common.[15] *Chiles*, 865 F.2d at 1213. For the same reasons recertification is appropriate, these requirements are also met. Thus, the court reaffirms its earlier conditional order granting the Hanna plaintiffs' motion to intervene.

Accordingly, it is ORDERED as follows:

(1) The court reaffirms its order of March 14, 1995 (Doc. no. 717), and grants the plaintiffs' motion for intervention, filed on March 10, 1995 (Doc. no. 702);

(2) The defendants' motion to recertify or modify the plaintiff class, filed December 22, 1994 (Doc. no. 417), and supplemental motion to recertify or modify the plaintiff class and alternative motion to decertify the plaintiff class, filed January 18, 1995 (Doc. no. 456), are granted to the extent that the plaintiff class is recertified, and the motions are denied in all other respects;

(3) A plaintiff class consisting of all current and future mentally-retarded and mentally-ill residents of any facility, hospital, center, or home, public or private, to which they are assigned or transferred for residence by

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[15] Subsection (b)(2) to Rule 24 provides:

"Upon timely application anyone may be permitted to intervene in an action: . . . when an applicant's claim or defense and the main action have a question of law of fact in common . . . In exercising its discretion the court shall consider whether the intervention will unduly delay or prejudice the adjudication of the rights of the original parties."

the Alabama Department of Mental Health and Mental Retardation, is certified pursuant to Fed.R.Civ.P. 23(a) & (b)(2), to be represented by Robert Hanna, Gregory Wolke, Jean Washington, Brent Bugsch, Benjamin Stokes, Stephanie Ramsey, and Eric Boothe; and

(4) The United States Magistrate Judge, with input from counsel for both plaintiffs and defendants, shall fashion and recommend to the court the following within 45 days from the date of this order:

(A) A procedure by which plaintiffs' counsel may give the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys) immediate notice of the issues in and status of this litigation;

(B) A procedure which will allow plaintiffs' counsel to give to the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys) regular and adequate notice of the issues in and status of this litigation; and

(C) A procedure by which plaintiffs' counsel may have regular and adequate access to the plaintiff class (including their guardians, caretakers, next-of-kin, and attorneys).

DONE, this the 3rd day of October, 1995.

/s/ Myron H. Thompson
UNITED STATES
DISTRICT JUDGE

Ricky WYATT, By and Through His Aunt and Legal Guardian, Mrs. W.C. RAWLINS, Jr., et al., Plaintiffs,
Diane Martin, et al., Plaintiff-Intervenors,

v.

Royce G. KING, as Commissioner of Mental Health and Mental Retardation, and the State of Alabama Mental Health Officer, et al., Defendants,
United States of America, et al., Amici Curiae.

Civ. A. No. 3195-N.
United States District Court,
M.D. Alabama, N.D.

May 14, 1992.

Ira Burnim, Washington, D.C., for proposed intervenor Bretz.

R. Emmett Poundstone, III, and Ricky Trawick, Alabama Dept. of Mental Health, Montgomery, Ala., Joel Kline, and Christopher Cerf, Washington, D.C., for King and Dept. of Mental Health.

R. David Christy, Montgomery, Ala., for King.

Andrew J. Barrick and Mitchell W. Dale, U.S. Dept. of Justice, Civ. Rights Div., Washington, D.C., for the U.S.

Byrd R. Latham, Patton, Latham, Legge & Cole, Athens, Ala., for Gunter, Steagall and Brassell.

David Ferleger, Philadelphia, Pa., Reuben Cook, Edward Stevens, Victoria Farr, and Donald Tipper, Tuscaloosa, Ala., for intervenors Martin, et al.

Peter G. Thompson, Sandra Lord, Washington, D.C., for Ricky Wyatt, et al.

Pamela Chen, U.S. Dept. of Justice, Civ. Rights Div., Sp. Litigation Section, Washington, D.C., for amicus curiae U.S.

Algert Agricola, Mark Montiel, and David Byrne, Montgomery, Ala., for State defendants.

MEMORANDUM OPINION AND ORDER

MYRON H. THOMPSON, Chief Judge.

In 1972, as a result of a class-action lawsuit brought on behalf of patients involuntarily committed to the custody and care of the Alabama Department of Mental Health and Mental Retardation, this court ordered departmental officials to comply with certain minimal constitutional standards in the provision of care to the mentally ill. *See Wyatt v. Stickney*, 344 F.Supp. 373 (M.D.Ala.1972), *aff'd in part*, 503 F.2d 1305 (5th Cir.1974). Although this litigation has undergone numerous developments since that time, these "*Wyatt* standards" for the mentally ill have remained largely unchanged since their adoption. Last year, the parties sought court approval of two consent decrees that proposed to modify several of the *Wyatt* standards. At that time, primarily because of the apparent lack of support for the consent decrees among the state's mental health consumers and their advocates, the court required the parties "to clarify or change the decrees where necessary and to submit additional evidence in support of the decrees." *Wyatt v. King*, 793 F.Supp. 1053, 1057 (M.D.Ala.1991). The parties, with the support of numerous mental health organizations, have now submitted three new consent decrees for the

court's approval. For the reasons that follow, the court will approve the entry of these new consent decrees.[1]

I.

It is well established that parties who seek to resolve a class action through settlement must first convince the court that the proposed settlement agreement constitutes a "fair, adequate and reasonable" resolution of the dispute.[2] *Holmes v. Continental Can Co.*, 706 F.2d 1144, 1147 (11th Cir.1983);[3] *see also* Fed.R.Civ.P. 23(e) (requiring judicial approval of any settlement negotiated in class action). Although the court will accord some deference to the opinion of class counsel, the court retains an independent obligation to ensure that counsel is acting in the best interest and with the support of his or her class. *Pettway v. American Cast Iron Pipe Co.*, 576 F.2d 1157, 1217-18 (5th Cir.1978), *cert. denied*, 439 U.S. 1115, 99 S.Ct. 1020, 59

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[1] With the submission of the three new decrees, the court entered a final order rejecting the two original decrees. *Wyatt v. King*, civil action no. 3195-N (M.D. Ala. Oct. 28, 1991).

[2] The court also has a duty to ensure that the settlement is not illegal, against public policy, or the product of fraud or collusion. *Dillard v. Crenshaw County*, 748 F.Supp. 819, 823 (M.D.Ala.1990). No one has leveled such a charge against the three new proposed decrees, and the court is unaware of any evidence which would support such a charge.

[3] In *Bonner v. City of Prichard*, 661 F.2d 1206, 1209 (11th Cir.1981), the Eleventh Circuit Court of Appeals adopted as binding precedent all of the decisions of the former Fifth Circuit handed down prior to the close of business on September 30, 1981.

L.Ed.2d 74 (1979); *Paradise v. Wells*, 686 F.Supp. 1442, 1444 (M.D.Ala.1988).

When parties to a consent decree subsequently propose to amend that decree, the trial court similarly must examine evidence submitted by the parties to determine whether the proposed modification is justified. It is the court's responsibility to "discern the underlying purpose of the decree and decide whether modification would be consistent with that purpose." *Hodge v. Dept. of Housing & Urban Dev't.*, 862 F.2d 859, 864 (11th Cir.1989) (per curiam); *see also Heath v. DeCourcy*, 888 F.2d 1105, 1110 (6th Cir.1989) (in institutional reform litigation, court considers whether parties have identified "defect or deficiency" in district court's original decree which impedes achieving decree's goals). Again, the fact that class counsel supports the proposed modifications is an important factor in the court's inquiry but is not the only relevant consideration; the court must still undertake an independent evaluation of the evidence submitted before lending the authority of the federal court to the agreement fashioned by the parties.

In this case, in January 1991, counsel for the plaintiff class and counsel for the defendants first jointly petitioned the court for approval of modifications to the existing *Wyatt* standards. The 35 standards address a broad spectrum of conditions and requirements, governing virtually every area of patient life within the state's mental health institutions, from showers to psychiatrist staffing ratios, from "electro-convulsive treatment" to therapeutic labor. Through two consent decrees, the parties proposed to amend ten of these 35 standards, including those governing the administration of electro-

convulsive treatment and the use of "seclusion and physical restraint."

At that time, the court examined the decrees, reviewed the arguments presented by counsel in support of their adoption, and encouraged interested parties to present the court with their views on the proposed changes. As a result of this process, it became clear to the court that counsel for the plaintiff class had failed to take sufficient steps – or, it appeared, any steps whatsoever – to solicit comments from class members and their advocacy organizations during the development of the decrees. At the fairness hearing, counsel were unable to present any evidence that would indicate the support of class members for these revisions. On the contrary, the court heard from numerous mental health consumers and their advocacy organizations who expressed strong criticisms of the proposed modifications. In addition, the court had its own questions about the application of the proposed decrees and the impact on current practices at state facilities. Because counsel had failed to present sufficient evidence to establish that the modifications were necessary to remedy a deficiency in the standards as they existed or that the proposed changes would be in the "best interest" of the class, the court refused to approve these decrees. Hodge, 862 F.2d at 861-64. The court directed counsel for plaintiffs and defendants to gather additional evidence in support of the decrees and to clarify or change the decrees as necessary to obtain wider support from the class members and their representatives. 793 F.Supp. at 1057.[4]

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[4] *See* note 1, *supra*.

The three new consent decrees currently before the court differ in many respects from those submitted to the court previously; most importantly, these decrees, unlike the earlier versions, now appear to have the support of a large segment of the mental health community. This is primarily due to the efforts of counsel for the plaintiff class and counsel for defendants to involve the state's primary and secondary consumers,[5] consumer organizations, and advocacy groups – including counsel for the plaintiff-intervenors in this case – in the revision of the decrees.[6] Counsel for the parties circulated copies of the proposed decrees to these various groups and individuals for their inspection and comment, and encouraged them to submit written comments or affidavits to the court and to make their views known at the fairness hearing. Throughout the weeks preceding the fairness hearing on the three new decrees, the court continued to receive

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[5] "Primary" consumers are mental health patients themselves; "secondary" consumers are the families and friends of mental health patients who are affected by the standard of state mental health services.

[6] The plaintiff-intervenors, who are seeking to represent those members of the *Wyatt* plaintiff class who are involuntarily confined at the Thomasville Adult Adjustment Center, have also participated in the settlement process. Although not directly involved in this phase of the litigation, their counsel are familiar with the implementation of the *Wyatt* standards at the Thomasville facility and have provided the parties and the court with useful insight into the possible impact of the proposed revisions on patients at that facility. Plaintiff-intervenors' counsel have also assisted by suggesting amendments to the *Wyatt* standards designed to ensure the timely identification and discharge of patients who no longer meet commitment criteria. *See Wyatt v. King*, 773 F.Supp. 1508 (M.D.Ala.1991).

revisions as counsel for the parties sought to respond to comments and criticisms they received.

The willingness of counsel for the parties to address the concerns of their critics has had two very positive results: first, the decrees now before the court have the support of the state's major mental health advocacy organizations; and, second, upon reviewing the decrees, the court finds that they are much improved substantively as a result of the numerous revisions.[7] The court is confident that enactment of these proposed modifications will improve the standard of care for patients committed to the state's mental health facilities and thus better promote the underlying purpose of the original *Wyatt* order. Hodge, 862 F.2d at 864. The following section offers a general discussion of the existing standards and the more salient modifications advanced in the three proposed consent decrees.[8]

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[7] In a previous order, the court wrote that it "understands the difficulties class counsel faces in endeavoring to solicit the views" of "his clients – who consist only of current patients confined in state mental health facilities." 793 F.Supp. at 1055-56. Counsel for the plaintiff class, Mr. Ira Burnim, is to be strongly commended for the sensitive and effective manner in which he has involved many affected and interested persons in the settlement proceedings.

[8] The three decrees now before the court address the same standards that the parties' counsel sought to modify in the original two decrees. The "addition" of a third decree results from counsel's decision to submit the revised standard on seclusion and restraint and the revised electroconvulsive treatment standard as two separate decrees.

II.

A. The First Consent Decree

(Standards 21, 23, 26-29, 31, and 33)

The first of the proposed consent decrees would alter *Wyatt* standards 21, 23, 26-29, 31, 33, and the definitional section of the standards. These revisions address two of the three issues identified by the original *Wyatt* court as areas of "fundamental" concern: "qualified staff in numbers sufficient to administer adequate treatment," and the "individualized treatment plans." 344 F.Supp. at 375. In addition, the decrees change some of the terminology used in the standards to account for the new facilities that have been created since 1972.

i. Clarification of definitions

In 1972, when the court promulgated the original *Wyatt* standards, Bryce and Searcy Hospitals housed the State of Alabama's involuntarily-committed mentally ill patients. Accordingly, the court applied the minimum treatment standards for such patients to "hospitals." *See Wyatt*, 344 F.Supp. at 379-386 (standards 18(A), 19(F) & (G), & 24). Since 1972, however, the state has established additional mental health institutions, some of which, such as the Eufaula Adolescent Center and the Thomasville Adult Adjustment Center, are not designated as hospitals. The parties therefore have proposed amending the *Wyatt* standards to make clear that the standards for treatment of people with mental illness apply not only to "hospitals" but to all state-operated "facilities." The list of institutions specifically identified as hospitals is

also updated to include North Alabama Regional Hospital and Greil Memorial Hospital. Finally, the proposed decree would specify that any reference to "patients" includes not only hospital patients but all those individuals involuntarily committed to any state facility.

ii. "Qualified mental health professionals" or "QMHP's"

One of the central concerns animating the court's adoption of the original *Wyatt* standards was the lack of adequate qualifications among the departmental employees involved in the care of patients committed to the state's mental health institutions. *See Wyatt v. Stickney*, 325 F.Supp. 781, 783 (M.D.Ala.1971). Accordingly, in its 1972 order, the court obligated state officials to provide mental health treatment to these residents through properly trained and experienced staff. In particular, the court created four categories of "qualified mental health professionals" or "QMHP's," authorized by the *Wyatt* standards to plan and administer treatment.[9]

In earlier proposals, the plaintiffs and defendants sought to expand the definition of QMHP's substantially, to include a wider range of social workers, nurses, and

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[9] Under the existing standard, the following four groups may serve as QMHP's: (1) psychiatrists with three years of residence training in psychiatry; (2) psychologists with doctoral degrees from accredited programs; (3) social workers with master's degrees from accredited programs and two years of clinical experience under the supervision of a QMHP; and (4) registered nurses with graduate degrees in psychiatric nursing and two years of clinical experience under the supervision of a QMHP. *See Wyatt*, 344 F.Supp. at 379.

doctors. In response to strenuous objections from consumer advocacy groups, the parties have limited the expansion to the addition of two categories of "psychological associates." These psychological associates would be psychologists with master's degrees and two years of clinical experience under the supervision of a doctoral level clinical psychologist who fall in one of the two following groups: (1) those with master's degrees from accredited clinical programs providing specialized training in abnormal behavior, and (2) those with degrees in another area of psychology, but who have received training in abnormal behavior and are employed in one of the covered state institutions on the date the decree takes effect. Plaintiffs' counsel has indicated that this expansion will have limited impact on patient care, as master's level psychologists already perform many of the tasks of a QMHP at state facilities. Their explicit inclusion as QMHP's will permit them, when appropriate, to approve formally [sic] treatment plans and to approve certain orders in the plans regarding visitation, mail and telephone communication, wearing personal clothing and keeping and using personal items.

The revised standards also change the terminology used to refer to staff who are not QMHP's as "non-QMHP" staff instead of "non-professional" staff.

iii. Licensing and certification requirements for QMHP's

The existing standard 21 mandates that both QMHP's and non-QMHP's in each field shall meet all licensing and certification requirements promulgated by the state for their profession or specialty. The proposed decree

would amend this standard to clarify the QMHP status of certain social workers and to permit certain psychiatrists who are awaiting full licensure to serve as QMHP's for a period of one year. The decree would also revise standard 23, which requires that each non-QMHP be supervised by a QMHP, to specify that the supervisor must be a QMHP "appropriate to the work assignment and professional discipline" of the non-QMHP staff member.

iv. Individualized treatment plans

The first consent decree proposes several changes in the existing standards governing the development, implementation, supervision and review of patient treatment plans by mental health staff. Structurally, the modifications would consolidate existing standards 26 through 29 and 33 into a single standard. Substantively, the revisions incorporate recommendations made by consumers and advocates to ensure that patients understand their treatment goals and that these goals relate to the criteria for discharge.

(a) Development of the individualized treatment plan

Standard 26 of the court's 1972 order required that an individual treatment plan for each patient be developed by "appropriate Qualified Mental Health Professionals, including a psychiatrist." *Wyatt*, 344 F.Supp. at 384. The revised standard clarifies that treatment plans must be developed by "an assigned Treatment Team," and that teams within hospitals must be headed by a psychiatrist

and those in geriatric programs and in the Thomasville Adjustment Center and the Eufaula Adolescent Center by "an appropriate QMHP." The existing standard 33 allows 15 days for the creation of an individualized treatment plan. As revised, the standard now requires that a member of the treatment team examine the patient and develop an interim treatment plan within 72 hours of admission. The treatment team would have ten days to develop and implement a fully individualized plan.

The revised standard also adds to the elements which must be included in each patient's individualized treatment plan. In addition to the information already required, the treatment plan must include: "a statement of the patient's strengths including skills and interests," "an assessment by medical staff of any restrictions or limitations on physical activity," and intermediate and long-range treatment goals. Criteria for release to less restrictive treatment conditions and criteria for discharge must be "specific and measurable," must be "written in nontechnical language," and must be "explained to the patient in a manner appropriate to the patient's capacity to understand." The intermediate and long-term treatment goals must be clearly stated and "must relate to involuntary commitment criteria"; similarly, criteria for release must "relate to involuntary commitment standards." As part of the treatment plan, the treatment team must also develop an individualized discharge plan that identifies the different services the patient will require upon discharge.

(b) Supervision of treatment

The revised standard specifies that, once a plan has been developed that includes all of these elements, a QMHP and a psychiatrist must bear responsibility for overseeing the implementation of the treatment plan, integrating the various components, reviewing the plan regularly, and recording the patient's progress. As before, the QMHP bears responsibility for ensuring that the patient is released to a less restrictive form of treatment when appropriate; in addition, however, the revised standard requires the QMHP to see that, upon discharge, the patient receives the appropriate transitional services.

(c) Progress summaries

The parties have also agreed to alter the requirements concerning the entry of progress summaries and the review of treatment plans. For most patients, the revision does not affect the current standard's requirement of weekly progress summaries by a QMHP but simply recasts this requirement as a "minimum" and instructs the QMHP to update the report more frequently as necessary, that is, "on a regular and periodic basis . . . as dictated by good clinical judgment." For patients in long-term treatment programs and geriatric patients, the standards would instead require only monthly progress summaries. Added is a requirement that progress summaries include a "medication review" that monitors the efficacy of any prescribed medication and the presence of unintended side effects.

(d) Review and modification of treatment plans

The revised standard seeks to regularize the review of treatment plans to ensure that appropriate modifications may be made in a timely fashion. Currently, standard 29 requires "continuous" review, and modifications "if necessary," but offers no precise guidance beyond the requirement that a review be conducted at least every 90 days. The revised standard specifies that a patient's treatment plan is to be reviewed "at major key decision points in the patient's treatment, including: at the time of admission, transfer, and discharge; when there is a major change in the patient's condition; at the point of estimated length of treatment and thereafter based on that estimated length of treatment;" and, at a minimum, every 90 days. Modifications are to be made by the treatment teams "as the need becomes evident through regular and periodic reviews." Because the new standards provide for a treatment team, rather than an individual QMHP, to develop and implement the treatment plan, the requirements that a patient periodically receive a mental examination from a QMHP other than the professional responsible for his or her care, and that a non-attending QMHP review the treatment plan, have both been eliminated.

(e) Quality assurance and utilization review

To ensure that the theoretical benefits of the improved standards are realized in practice, the parties have fashioned a new standard requiring each mental health facility to maintain a "quality assurance program,"

to guarantee that treatment plans are reviewed in accordance with accreditation standards, and a "utilization review program," to screen patients to determine whether they have been appropriately admitted and to reexamine periodically each patient's need for continued inpatient treatment. The latter provision would replace an existing standard that requires the superintendent of a hospital to examine a patient and decide whether the patient requires hospitalization within 15 days of the patient's admission. In its stead, the revised standard mandates that the need for continued inpatient treatment be determined according to a schedule based on the average length of stay for the unit or program in which the patient is being treated. If the data for the patient's individual unit or program are not "readily available," the staff may use instead length of stay data for the entire facility.[10] As part of the admissions screen and the continued stay reviews, the facility must document the specific basis supporting its determination that a patient requires admission or continued institutional care.

The revised standard takes the important step of clarifying the facility's obligation to terminate the involuntary commitment of patients who do not meet commitment standards. If, as a result of the admissions screen or a continued stay review, the facility determines that the

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[10] Plaintiff-intervenors repeatedly expressed concern that calculations of the average length of stay for the facility as a whole would bias the length of stay toward longer periods of hospitalization, as the high volume and fast turnover of the admissions unit would obscure the actual length of stay on the long-term unit. The current proposal seeks to accommodate this concern where such data are available.

patient does not meet the standards for involuntary commitment, "the patient must be released immediately unless he or she agrees to continue on as a voluntary patient." The revised standard similarly requires that if, at any point during a patient's stay, the facility director or the director's appointed representative determines that the patient no longer meets the criteria for involuntary commitment, the patient must be discharged immediately, unless he or she decides to stay on as a voluntary patient, and must be provided with the appropriate transitional services.

v. Patient records

The parties propose to modify standard 31, which concerns patient records, to emphasize the importance of the confidentiality of patient records and to clarify that this must be protected "through strict adherence to applicable statutes and rules." The revised decree would also modify the current requirement that all individuals seeking access to a patient's record must first obtain written authorization from the patient or the patient's guardian. The revised standard identifies a limited number of individuals, including the patient's attorney, authorized Department employees, and, to the extent legally authorized, the Alabama Disabilities Advocacy Program, who need not obtain a formal written consent in order to examine a patient's records. The standard also affirms that a patient must have access to his or her own records.

In response to comments and recommendations submitted by consumers, the new standard adds the requirement that any complaint about a patient that is recorded

in the patient's record be discussed with the patient, and that the patient's response be documented along with the complaint. The requirement that complete patient records be kept on the patient's ward has been deleted.

B. The Second Consent Decree: Seclusion and Restraint (Standard 7)

Among the most rigorous procedural protections adopted by the court in its 1972 order were those designed to protect the rights of mental health patients against the unfettered use of such extraordinary measures as electro-convulsive treatment, and isolation (or seclusion) and physical restraint. The second consent decree proposes several changes in the procedures governing physical restraint and seclusion designed to increase the protections for patients and to reflect current professional standards.[11] Revisions to the standards governing use of electro-convulsive treatment are addressed in the third decree.

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[11] In a footnote, the decree suggests that the plaintiffs and the defendants "may agree to apply a different standard" to the Eufaula Adolescent Center. Counsel for the parties have explained to the court that, because this facility is in a state of flux and because its future is thus uncertain, the parties were unable to agree on how the procedures governing restraint and seclusion should be modified to apply to it. The court understands from the parties that the Eufaula Adolescent Center will therefore continue to be governed by the existing procedures.

The original *Wyatt* standard authorized the use of seclusion or restraint in both emergency and non-emergency situations but established different standards applicable to the two situations. In the absence of any emergency, the original standards permit a patient to be physically restrained or isolated on the written order of a QMHP who has "personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation." Such an order could remain in effect for a maximum of 24 hours, after which time it would need to be "renewed" if physical restraint and isolation were to be continued.[12] In an emergency, defined as a situation in which "it is likely that patients could harm themselves or others," an order for restraint or isolation could be approved by any staff member for a period of up to one hour if the staff member found that "less restrictive means of restraint are not feasible." An emergency order for restraint or isolation could not extend beyond this initial one hour period unless a QMHP was consulted and entered an appropriate order in writing. 344 F.Supp. at 380.

Unlike the current standard, the revised standard makes clear that a patient may be physically restrained "only . . . to prevent [the] patient from physically injuring himself/herself or others"; even non-emergency use of restraint or seclusion is governed by this requirement. It

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[12] The existing standard also requires that the patient be seen by "qualified ward personnel" who will record the patient's physical and, if appropriate, psychological condition at least every hour; that the patient receive "bathroom privileges" every hour and be bathed every 12 hours; and that the patient be provided meals regularly.

emphasizes that "[s]eclusion and restraint shall not be used as punishment or for the convenience of staff or in a manner that causes undue physical discomfort, harm or pain to the patient." The revised standard substantially limits the number of staff members authorized to order non-emergency seclusion or restraint: only a "qualified physician," defined as a psychiatrist or a licensed physician with specialized training, possesses this authority. The physician must be physically present and must perform an examination of the patient prior to issuing the order. Previously, the standard permitted a patient to be kept in seclusion or restraint for up to 24 hours on the basis of the initial order; the revised standard shortens this time to a maximum of eight hours. The new standard would also require that the patient be monitored every 15 minutes, as opposed to every hour under the present standard, and be bathed at least every 24 hours, rather than every 12 as is presently the rule. In response to the recommendations of advocacy groups, the standard also specifies that the staff member monitoring the patient shall be made aware of any special medical concerns regarding the patient so that these may be taken into account.

Like the 1972 order, the proposed decree recognizes an exception to the ordinary requirements when the use of isolation and physical restraint is required in "emergency situations." As with non-emergency orders, however, the procedural safeguards governing emergency restraint and seclusion are much improved. The existing standard does not require the involvement of medical personnel in implementing emergency seclusion and restraint, and permits the extension of emergency orders

for up to 24 hours at a time as long as a QMHP is "consulted" within the first hour of the emergency episode and approves an extension of the order. This standard has been rewritten to ensure that even in "emergency" situations the use of seclusion and restraint is carefully controlled. As revised, the standard permits "a trained, clinically privileged, qualified registered nurse" to approve a seclusion or restraint order "in emergency situations when no qualified physician is available," but only if alternative treatment interventions "have been unsuccessful or would not prevent injury" and the use of seclusion or restraint is necessary "to prevent a patient from physically injuring himself/herself or others."[13] Before approving an order for seclusion or restraint, the nurse must be physically present and must evaluate the patient's condition "to the extent . . . feasible"; this evaluation is to be documented in the patient's record. If all the preceding requirements are met, the nurse may order the use of seclusion or restraint for a period of up to one hour. The revised standard requires that a qualified physician be notified as soon as possible after the emergency episode begins, and that

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[13] To meet the training standards, the nurse must be a QMHP registered nurse or a licensed registered nurse who has two years of clinical experience, has completed a basic ten-hour course addressing the use of psychopharmacology, psychopathology, and psychotherapeutic interventions (such as seclusion and restraint), and who obtains 20 hours of continuing professional education credits annually, half of them in areas relating to the treatment of patients with mental illness. The ten-hour educational course is to be developed by the Department of Mental Health and Mental Retardation in consultation with consumers and ex-patients.

such a physician must see the patient in person within four hours – preferably, within one hour.

A qualified doctor may verbally order that the emergency one-hour episode of seclusion or restraint be extended for up to four hours (three hours beyond the nurse's original order) if the doctor finds that this action is necessary to prevent physical injury to the patient. No emergency episode may last longer than four hours; after that time, any additional seclusion order must comply with the standard governing non-emergency use of seclusion and restraint. All written orders for seclusion and restraint, including emergency orders, must include a clinical assessment of the patient, the alternative treatment interventions attempted, and criteria for the release of the patient that relate to the original reasons for the intervention.

Finally, the revised standard adds requirements regarding the management of patients in seclusion and restraint. It mandates that patients be provided "fluids" as well as meals on a regular basis; that patients' vital signs must be taken "as clinically indicated"; and that patients in restraint must "be released for range of motion exercises as clinically indicated."

C. The Third Consent Decree: Electro-Convulsive Treatment or "ECT"

(Standard 9(3))

As initially established in 1972, the *Wyatt* standards required only that a patient have given "express and informed consent" before any administration of electro-convulsive treatment or "ECT". *Wyatt*, 344 F.Supp. at 380.

In 1980, however, the court instituted a fairly elaborate procedural mechanism for approving and administering the treatment.[14] This new procedure required that a QMHP trained and experienced in ECT use recommend the treatment in writing; that the recommendation be concurred in by another QMHP trained and experienced in its use and approved by the superintendent or medical director of the hospital and by the "Extraordinary Treatment Committee," a five-member court-appointed body; and that the patient give written, informed consent. The procedure placed a number of significant responsibilities on the Extraordinary Treatment Committee, including that it certify that the patient's consent was actually "knowing, intelligent, and voluntary", ascertain that the proposed treatment constituted the "least drastic alternative available", "give great weight to any expression by the patient of a desire not to be subjected to ECT", and resolve "[a]ny doubts that ECT is in the best interest of the incompetent patient . . . against proceeding with such treatment." Finally, the court required that each patient be represented throughout these proceedings by an independent attorney.

In the case of a patient incompetent to give informed consent, the 1980 order mandates alternative procedures for obtaining approval of ECT. If such an individual is

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[14] *Wyatt v. King*, civil action no. 3195-N (M.D.Ala. July 25, 1980). The court adopted this new standard "for the purpose of eliminating any confusion or ambiguity and to continue the procedural safeguards that must accompany the use of extraordinarily or potentially hazardous modes of treatment on patients in the state's mental institutions." *Id.* at 1.

deemed incompetent by either his or her attorney, treating psychiatrist, or the Extraordinary Treatment Committee, the Committee may consent to such treatment on the patient's behalf if, after a comprehensive evaluation of the patient and his or her records, and taking account of the wishes of the patient, the patient's family members, and the hospital staff, it finds that the treatment would be in the patient's best interest. Either the patient or a family member may seek court review of such a decision before ECT is begun.

Once such treatment has been approved, the 1980 order also constrains how it may be administered. First, within ten days prior to the beginning of each series of ECT, the patient must receive a complete physical and neurological examination. Second, such treatment may only be administered by a QMHP psychiatrist, trained and experienced in the use of ECT, or by "qualified personnel" under the "direct supervision and in the physical presence" of such trained psychiatrist. Third and finally, a competent patient is entitled to withdraw his or her consent to such treatment at any time and for any reason.

In the proposed consent decrees submitted to the court last year, which the court refused to approve, the parties sought to make substantial modifications in the procedures for ECT. In particular, the proposed decrees placed the entire process under independent judicial supervision by eliminating the Extraordinary Treatment Committee and transferring to state courts the responsibility for determining a patient's competency to consent to treatment and approving the administration of ECT. Furthermore, because counsel for the parties assumed

that state courts would continue to appoint counsel in cases such as these, the proposed decrees eliminated the Department's obligation to provide each patient with an independent attorney. In addition, among other things, the decrees required that a consulting psychiatrist, not affiliated with either the Department or the treating psychiatrist, examine the patient and concur in the recommendation for ECT, and the decrees recognized a new category of "emergency" ECT for situations in which the delay inherent in ordinary procedures could be expected to jeopardize the patient's life or cause the patient serious physical harm.

Although the parties' counsel believed the proposed modifications on the whole strengthened the protections provided to patients, some consumers and advocacy groups voiced a number of concerns, in particular about the elimination of the Extraordinary Treatment Committee. In response to these concerns, the parties have proposed a new decree which, like the earlier proposals, still strengthens the protections provided to patients, but does so through less radical revisions to the procedures governing ECT.

The proposed decree preserves the Extraordinary Treatment Committee but provides that it shall be "reconstituted" by the court to ensure that consumers or ex-patients are represented as committee members.[15]

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[15] The exact composition of the reconstituted committee is left for the court to determine, with the assistance of the parties, after approval of the revised decrees. The Committee would continue to function in its present form until the changes contemplated by the revised standard are implemented.

Although the above-listed substantial responsibilities of the Committee are conspicuously absent, these concerns have not been overlooked: the decree provides that the court is to "prescribe rules of the Committee's functioning." The decree further limits those who may prescribe ECT to "a psychiatrist . . . who has training regarding the appropriate use of ECT, has conducted a thorough mental and physical examination of the patient, and reviewed the medical records available." The revised standard also spells out more clearly the information that must be provided a patient before the patient's informed consent may be obtained. This provision reflects the concerns expressed by some class members that, in the past, patients may have consented to ECT without fully understanding the potential side effects. The protections established by the court in 1980 for non-emergency ECT should be, depending upon the oversight duties ultimately assigned to the reconstituted Extraordinary Treatment Committee, somewhat strengthened with the implementation of the decree.

The revised standard provides for the administration of ECT to a patient who is not competent to consent to treatment and for whom no guardian has been appointed, in certain "emergency" situations. In the absence of a consent obtained according to the standard described above, ECT may be administered only when the treating psychiatrist has documented, and the Extraordinary Treatment Committee confirmed, that the following conditions are met: (1) the patient's condition has deteriorated; (2) the patient has failed to respond to alternative forms of treatment; and (3) a delay in treatment "could reasonably be expected to jeopardize the life of the

patient or to result in serious physical harm to the patient." Before invoking this emergency provision, the treating psychiatrist must first notify the Department's Internal Rights Advocacy and Protection Program and must diligently petition the state court to appoint a guardian or provide judicial authorization for the treatment. Only if the psychiatrist is unable to secure a decision from the state court may the "emergency" treatment proceed.[16] Finally, the revised standard directs the Internal Rights Advocacy and Protection Program to conduct an annual review of all administrations of ECT, both emergency and non-emergency.

The court recognizes that not all class members are happy with the revised standard. Although the use of ECT has gained increased acceptance in the medical community since the court first established procedures governing its use in 1972, it continues to generate controversy among members of the mental health community. Testimony submitted to the court confirms that, other than seclusion and restraint, ECT is the treatment modality of greatest concern to consumers. The court heard from a number of consumers and advocates who object to any use of "emergency" ECT on patients unable to give voluntary consent. These critics assert that ECT is a very invasive form of therapy which carries serious side

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[16] To avoid the prospect of repeated "emergency" orders approving the use of ECT, the standard directs that if the treating psychiatrist anticipates that future ECT treatments may be indicated, the psychiatrist must make "diligent efforts" following the emergency treatment to obtain a judicial determination of the patient's competency and, if necessary, the appointment of a guardian.

effects, most notably memory loss, even when appropriately used. In light of these risks, critics of the "emergency" use provision would have preferred that the standard be modified to prohibit such use altogether. And although the focus of most objections centered upon "emergency" use of the treatment, critics have also sought increased assurance that the treatment will be used only as therapy of last resort, and that patients who consent to treatment will be provided with full information about the treatment and its risks.

For the most part, however, even critics of ECT agreed with the court that the revised standard represents an improvement over the existing *Wyatt* standard.[17] The decree retains existing patient safeguards, such as the appointed attorney and the Extraordinary Treatment Committee, and establishes some additional protections. The exception for "emergency" treatment is narrowly defined and should not result in any increased use of the therapy. Finally, the court notes that this standard has been modified in the past and, if necessary, may be revised again in the future, as medical knowledge about

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[17] The plaintiff-intervenors remain opposed to federal court involvement in the administration of ECT, fearing that the proposed decree will encourage the Department to "bypass" state law protections regarding informed consent. The plaintiff-intervenors also question the need for this provision, contending that it is based solely on anecdotal evidence that, on occasion, some state courts have failed to process emergency requests expeditiously. The court assumes that the defendants will comply with the standards in making "diligent" efforts to secure a state court decision, and that this provision will therefore be invoked infrequently, if at all. Informed consent will remain primarily an issue for the state courts to resolve.

the risks and benefits of ECT indicates that further revision would better protect the interests of the state's mental health patients.

Accordingly, for the above reasons, it is the ORDER, JUDGMENT, and DECREE of the court that the joint request for entry of consent decrees filed by plaintiffs and defendants on January 10, 1991, be and it is hereby granted to the extent that the three new proposed consent decrees, submitted to the court on October 15, 1991, and later revised, are approved and entered this date.

CONSENT ORDER I

The plaintiffs and defendants have agreed that certain definitions and standards contained in the Court's prior orders regarding the care and treatment of persons with mental illness should be modified to both enhance the treatment of class members and better protect their rights. They have asked the Court to approve these modifications. For the reasons set forth in the Memorandum Opinion entered this date, the modifications will be approved.

Accordingly, it is ORDERED, ADJUDGED AND DECREED that the definitions section of the *Wyatt* standards concerning the care and treatment of persons with mental illness and Standards 21, 23, 26, 27, 28, 29, 31, and 33 concerning the care and treatment of persons with mental illness be and are hereby AMENDED as set out in the Appendix to this order.

APPENDIX TO CONSENT ORDER I OF MAY 14, 1992

Modifications of Standards Governing Care and Treatment of Class Members with Mental Illness

Definitions

a. "Facility" – One of the inpatient institutions for persons who are mentally ill operated by the Department of Mental Health/Mental Retardation, including hospitals, the Thomasville Adult Adjustment Center, and the Eufaula Adolescent Center.

b. "Hospital" – Bryce Hospital, Searcy Hospital, North Alabama Regional Hospital, and Greil Memorial Hospital, and any other state hospital operated by the Department of Mental Health and Mental Retardation in which class members reside.[1]

c. "Patients" – All persons who are now confined and all persons who may in the future be confined to any facility operated by the Alabama State Department of Mental Health/Mental Retardation pursuant to an involuntary civil commitment procedure.

d. "Qualified Mental Health Professional" –

(1) a psychiatrist with three years of residency training in psychiatry;

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[1] There is a long-standing dispute between the parties concerning whether the *Wyatt* standards are applicable to the Taylor Hardin Secure Medical Facility. This Consent Order is not intended to take a position on the matter, but instead to leave the question open to future judicial resolution if necessary. The Court understands that the parties have no intention to request such a resolution in the foreseeable future.

(2) a psychologist with a doctoral degree from an accredited clinical psychology program; or a psychologist with a doctoral degree from another accredited applied psychology program (e.g. counseling) who is licensed to practice within the state and who has one year of clinical experience under the supervision of a QMHP clinical psychologist;

(3) a psychological assistant (i) with a master's degree in psychology from an accredited clinical program offering specialized training in abnormal behavior and with two years of clinical experience under the supervision of a doctoral level clinical psychologist and (ii) who practices under the supervision of a doctoral level clinical psychologist;

(4) a psychological assistant with a master's degree in psychology who (i) has training in abnormal behavior, (ii) has two years of clinical experience under the supervision of a doctoral level clinical psychologist, (iii) is employed in a facility on the date of the Consent Order adopting this Appendix, and (iv) who practices under the supervision of a doctoral level clinical psychologist;[2]

(5) a social worker with a doctorate or master's degree from an accredited program and two years of clinical experience under the supervision of a QMHP;

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[2] This provision affects no more than 9 psychological assistants now employed by the Department. These nine, and only these nine, would attain QMHP status as a result of this provision.

(6) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a QMHP; and

e. "Non-QMHP Staff Member" – An employee of a facility, other than a QMHP, whose duties require direct contact with or supervision of patients.

Standard 21

(21) Each Qualified Mental Health Professional shall meet all licensing and certification requirements promulgated by the State of Alabama, if any, for persons engaged in private practice of the same profession elsewhere in Alabama.[3] Other staff members shall meet the same licensing and certification requirements promulgated by the State of Alabama, if any, as persons who engage in private practice of their specialty elsewhere in Alabama. Notwithstanding the preceding, psychiatrists who have proven their proficiency in the practice of medicine by the successful completion of required examinations and who have been approved and granted a limited institutional license by the State Board of Medical Examiners may be employed for up to one year.

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[3] This standard does not require that a social worker in a facility have a license for private independent practice (commonly referred to as a "P.I.P." license). It is sufficient that the social worker be licensed by the relevant state agency for private social work practice under the supervision of an appropriate professional.

Standard 23

(23) Each non-QMHP staff member shall be under the supervision of a QMHP appropriate to the work assignment and professional discipline of that non-QMHP staff member. Additionally, the treatment of each patient shall be supervised by a QMHP, and the non-QMHP staff members involved in carrying out treatment activities prescribed in the patient's treatment plan shall be responsible to that QMHP.

Standard 26

(26) A. Individualized Treatment Plan Development and Implementation.

Each patient shall have an individualized treatment plan developed by an assigned Treatment Team. The team shall actively involve the patient, and with the patient's permission, the patient's family, in developing the plan. Teams in treatment programs within a hospital must be headed by a psychiatrist, and teams in geriatric programs and in treatment programs in the Thomasville Adult Adjustment Center and the Eufaula Adolescent Center must be headed by an appropriate QMHP. The treatment plan shall be developed and implemented as soon as possible. At a minimum: within 72 hours of admission, a designated member of the Treatment Team shall develop a treatment plan based on, at least, an assessment of the patient's presenting problems, physical strength, emotional status, and behavioral status; and within ten days, a full individualized treatment plan shall be developed.

Each individualized treatment plan (other than the 72-hour plan), regardless of facility, shall contain:

(1) A statement of the nature of the specific problems and specific needs of the patient;

(2) A statement of the patient's strengths including skills and interests;

(3) A statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment and the goals of the treatment plan;

(4) A description of intermediate and long term treatment goals which relate to involuntary commitment criteria, with a projected timetable for their attainment;

(5) A specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

(6) Specific and measurable criteria for release to less restrictive treatment conditions, and specific and measurable criteria for discharge which relate to involuntary commitment standards. These criteria shall be written in nontechnical language and shall be explained to the patient in a manner appropriate to the patient's capacity to understand.

(7) A notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18, *supra;*

(8) An assessment by medical staff of any restrictions or limitations on physical activity;

(9) An individualized discharge plan developed concurrently with the individualized treatment plan that identifies the residential, clinical, social and vocational services the patient will require upon discharge.

B. Individualized Treatment Plan Supervision.

A QMHP and a psychiatrist shall be responsible for supervising the implementation of the treatment plan, integrating the various components of the treatment program, reviewing the treatment plan on a regular and periodic basis, and recording the patient's progress. The QMHP shall be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment. The QMHP shall ensure that, upon discharge, the patient is linked to an appropriate community mental health center and is given access to case management services.

C. Progress Summaries.

Summaries of the patient's progress shall be recorded on a regular and periodic basis by a QMHP. The progress summaries shall include a medication review by the attending psychiatrist or physician that specifically addresses, among other things, the extent to which the prescribed medication is achieving its intended purposes and the presence of unintended side effects. A summary of the extent and nature of the patient's work activity shall also be included, if applicable. The frequency and regularity with which the patient's progress is noted should be dictated by good clinical judgment. Factors affecting the exercise of such judgment should include changes in the patient's condition and/or the need to document observations that affect treatment planning. At a minimum, progress summaries shall be recorded as follows:

(1) Weekly summaries for patients in short-term treatment programs (programs of up to 180 days)[4] and in adolescent treatment programs;[5]

(2) Monthly summaries for patients in long-term treatment programs (programs of more than 180 days);[6]

(3) Monthly summaries for geriatric patients.

D. Individualized Treatment Plan Review and Modification.

Modifications in the individualized treatment plan shall be made by the Treatment Team as the need becomes evident through regular and periodic reviews.

At a minimum, the treatment plan shall be reviewed at major key decision points in the patient's treatment, including: at the time of admission, transfer, and discharge; when there is a major change in the patient's condition; at the point of estimated length of treatment and thereafter based on that estimated length of treatment; and at least every three months.

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[4] Currently, these programs include the North Alabama Regional Hospital, the Greil Memorial Hospital, and the admissions units at Bryce and Searcy Hospitals.

[5] Currently, the only such program is the adolescent unit at Bryce Hospital.

[6] Currently, the Eufaula Adolescent Center and the Thomasville Adult Adjustment Center are considered long-term treatment programs, as are Bryce and Searcy Hospitals, except their admissions units.

E. Quality Assurance/Utilization Review.

Each facility shall have a Quality Assurance Program that provides for all treatment plans to be reviewed in accordance with JCAHO standards and a Utilization Review Program that requires that all patients be screened for appropriateness of admission to the facility according to specific criteria, including whether the patient meets the standards for commitment. The Utilization Review program shall also require that the facility review a patient's need for continued inpatient treatment according to a schedule based on the average length of stay for the unit or program in which the patient is being treated.[7] The need for continued inpatient treatment shall be judged against specific criteria, including whether the patient continues to meet the standards for commitment. As part of the screen for appropriateness of admission and as part of the continued stay reviews, the facility shall document the specific basis for a determination that a patient needs to be admitted or continues to need institutional care.

If, as a result of the screen for appropriateness of admission or a continued stay review, it is determined that a patient does not require inpatient treatment in accordance with the standards for commitment, the patient must be released immediately unless he or she

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[7] The requirement that "the facility review a patient's need for continued inpatient treatment according to a schedule based on the average length of stay for the unit or program in which the patient is being treated" applies *only* when such data is readily available. When it is not, length of stay data for the facility will be used.

agrees to continue treatment on a voluntary basis. In addition, if at any time the director of the facility or his appointed, professionally qualified agent at any time determines that a patient does not require inpatient treatment in accordance with the standards for commitment, the patient must be discharged immediately unless he or she agrees to continue treatment on a voluntary basis. Upon discharge, the patient will be linked to an appropriate community mental health center and given access to case management services unless not clinically indicated.[8]

Standard 27

Standard 27 is deleted.

Standard 28

Standard 28 is deleted.

Standard 29

Standard 29 is deleted.

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[8] The parties anticipate that such linkage and access may not be clinically indicated in all cases in which a person is discharged on the basis that he/she is an inappropriate admission. In some of these cases, the person may not be mentally ill or may not require community mental health or case management services upon discharge.

Standard 31

(31) Confidentiality of the patient record shall be protected through strict adherence to applicable statutes and rules. Notwithstanding the preceding, the following shall have access to a patient's record: (a) the patient; (b) the patient's guardian; (c) individuals properly authorized in writing by the patient or the patient's guardian; (d) attorneys for the plaintiff class and their designated agents; (e) the Alabama Disabilities Advocacy Program, or its successor, in accordance with applicable law; and (f) properly authorized employees of the Alabama Department of Mental Health and Mental Retardation, including the staff of the Department's Internal Rights Protection and Advocacy Program. The record shall include at a minimum:

a. Identification data, including the patient's legal status;

b. A patient history, including but not limited to:

(1) Family data, educational background, and employment record;

(2) Prior medical history, both physical and mental, including prior hospitalization;

c. The chief complaints of the patient and the chief complaints of others regarding the patient. The chief complaints of others shall be discussed with the patient, and the patient's response shall be documented along with the complaints;

d. An evaluation that notes the onset of illness, the circumstances leading to admission, attitudes, behavior,

estimate of intellectual function, memory function, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;

e. A summary of each physical examination that describes the results of the examination;

f. A copy of the individualized treatment plan and any modifications thereto;

g. A copy of the individualized discharge plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

h. A medication history and status, including the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;

i. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;

j. The periodic summaries by the supervising QMHP of the patient's progress required by Standard 26, *supra,* including the summaries of the extent and nature of the patient's work activities;

k. A signed order by a QMHP for any restrictions on visitation and communication, as provided in Standards 4 and 5, *supra;*

l. A signed order by a qualified physician for any physical restraints or seclusion, as provided in Standard 7, *supra;*

m. A detailed summary of any extraordinary incident in the facility involving the patient to be entered by a staff member noting that he has personal knowledge of

the incident or specifying his other source of information, and initialed within 24 hours by a QMHP;

n. A summary of the findings of the screen of appropriateness of admission and of the continued stay reviews required by Standard 26, *supra,* and a summary of any finding by the director or his or her appointed agent that the patient does not require inpatient treatment in accordance with the standards for commitment.

Standard 33

Standard 33 is deleted.

CONSENT ORDER II

The plaintiffs and the defendants have agreed that Standard 9(3) contained in the Court's prior orders regarding the care and treatment of persons with mental illness should be modified to both enhance the treatment of class members and better protect their rights. They have asked the Court to approve the modification. For the reasons set forth in the Memorandum Opinion entered this date, the modification will be approved.

Accordingly, it is ORDERED, ADJUDGED AND DECREED that Standard 9(3) concerning the care and treatment of persons with mental illness be and is hereby AMENDED as set out in the Appendix to this order.

APPENDIX TO CONSENT ORDER II OF MAY 14, 1992

Modifications of Standard 9(3) Governing Care and Treatment of Class Members with Mental Illness

Standard 9(3)

Patients may be administered electro-convulsive treatment (ECT) provided the following conditions are met prior to implementing each course of treatment.

Basic Requirements

1. The patient is 19 years of age or older.

2. The treatment is prescribed by a psychiatrist licensed in the State of Alabama who has training regarding the appropriate use of ECT, has conducted a thorough mental and physical examination of the patient, and has reviewed the medical records available.

3. The Extraordinary Treatment Committee concurs in the recommendation of treatment. The Committee shall be reconstituted by the Court, after reviewing recommendations by the plaintiffs and the defendants for the Committee's reconstitution. In reconstituting the Committee, the Court will provide for representation on the Committee of consumers and/or ex-patients. The Court shall also prescribe rules for the Committee's functioning.

4. The clinical director of the facility has approved the decision to treat with ECT.

5. The treatment is administered by a psychiatrist who is specially trained in the use of ECT. Unless medically contraindicated, anaesthesia and muscle relaxants

are administered by a qualified anaesthetist or anesthesiologist or by a physician skilled in this procedure.

6. Regressive or depatterning electro-convulsive techniques are not utilized.

7. Complete, accurate, and contemporaneous records are maintained with respect to each administration of ECT.

8. Consent has been obtained in accordance with paragraphs # 9-# 12, or the emergency administration of ECT is permitted under paragraphs # 13-# 15 below.

Consent

9. For a competent patient (i.e., a patient who is capable of giving informed consent to ECT):[1]

a. The patient has been fully informed by the treating psychiatrist (in language and in a manner appropriate to the patient's condition and capacity to understand) of the nature, risks and consequences of ECT, including the possibility of memory loss; of the patient's right to revoke his consent at any time, including during the course of the treatment; and of specific means by which the patient may revoke his consent (e.g., by orally informing the treating psychiatrist or other staff, by calling a specific telephone number, by returning a pre-printed form, etc.); and

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[1] A psychiatrist may consider a patient to be "competent" when the psychiatrist reasonably believes the patient to be capable of giving informed consent to ECT.

b. The patient has consented in writing to the treatment.

10. If the patient has been judicially determined to be incompetent to consent to treatment (e.g., a court has appointed for the patient a general guardian or a limited guardian with power to consent to treatment), and the patient has not regained competency before or during the proposed course of ECT treatment:

a. The patient has been informed of the nature of the treatment in language and in a manner appropriate to the patient's condition and capacity to understand; and

b. Consent has been obtained in writing from the patient's guardian[2] after the guardian has been informed of the risks and benefits of the treatment, of the legal guardian's right to revoke consent at any time, and of specific means for revoking consent (e.g., by orally informing the treating psychiatrist or other staff, by calling a specific telephone number, by returning a pre-printed form, etc.).

11. If the patient has been judicially determined to be incompetent to consent to treatment (e.g., a court has appointed for the patient a general guardian or a limited guardian with power to consent to treatment), but the patient has regained competency before or during the proposed course of ECT treatment (regardless of whether the patient's guardian has consented to the treatment):

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[2] As used in this standard, a "guardian" includes any person authorized by a court of competent jurisdiction to consent on behalf of the patient to the administration of ECT.

a. The patient has been fully informed by the treating psychiatrist (in language and in a manner appropriate to the patient's condition and capacity to understand) of the nature, risks and consequences of ECT, including the possibility of memory loss; of the patient's right to revoke his consent at any time, including during the course of the treatment; and of specific means by which the patient may revoke his consent (e.g., by orally informing the treating psychiatrist or other staff, by calling a specific telephone number, by returning a pre-printed form, etc.); and

b. The patient has consented in writing to the treatment.

12. If a patient has not been judicially determined to be incompetent to consent to treatment, but the treating psychiatrist believes the patient may not be competent to consent:

a. The treating psychiatrist has caused a formal request (e.g. petition, motion, etc.) to be filed in a court of competent jurisdiction for adjudication of the patient's competence to consent to treatment;[3] and

b. Either:

(i) The court has appointed a guardian and the requirements of paragraph # 10 have been met; or

(ii) The court itself has authorized the treatment and the requirements of paragraph # 10a have been met.

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[3] Each such formal request filed in court must ask the court to appoint counsel for the patient whose competence is at issue.

Emergency Administration

13. Notwithstanding paragraphs # 9-# 12 above, patients may be administered ECT in an emergency if the following conditions have been met:

a. The treating psychiatrist has documented, and the Extraordinary Treatment Committee has found, that: (i) the patient is not competent to consent to treatment and is without a guardian; (ii) the patient's condition has deteriorated, (iii) the patient has failed to respond to alternative forms of treatment, (iv) a delay in treatment could reasonably be expected to jeopardize the life of the patient or to result in serious physical harm to the patient; and

b. The treating psychiatrist has:

(i) Notified the Department's Internal Rights Advocacy and Protection Program of his or her decision; and

(ii) Been unable to secure a decision on the appointment of a guardian or a judicial authorization from a state court to administer ECT on an emergency basis, despite diligent efforts on his part and the part of legal counsel for the Department.[4]

14. If the treating psychiatrist believes that the patient may require additional ECT treatment in the

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[4] Requests filed with the court for the appointment of a guardian or judicial authorization to administer ECT must ask the court to appoint counsel for the patient whose competence is at issue.

future, the Department must make diligent efforts following the emergency treatment to obtain a judicial determination of whether the patient is competent to consent and, if it is determined that the patient is not competent, to obtain the appointment of a guardian to consent to treatment or a judicial authorization for future ECT treatments.

Review by Internal Advocacy Program

15. The Department's Internal Rights Advocacy and Protection Program shall annually review all administrations of ECT (i.e., emergency administrations, administrations to consenting competent patients, and administrations to incompetent patients when a guardian or court has given consent).

CONSENT ORDER III

The plaintiffs and the defendants have agreed that Standard 7 contained in the Court's prior orders regarding the care and treatment of persons with mental illness should be modified to both enhance the treatment of class members and better protect their rights. They have asked the Court to approve the modification. For the reasons set forth in the Memorandum Opinion entered this date, the modification will be approved.

Accordingly, it is ORDERED, ADJUDGED AND DECREED that Standard 7 concerning the care and treatment of persons with mental illness be and is hereby AMENDED as set out in the Appendix to this order.

APPENDIX TO CONSENT ORDER III OF MAY 14, 1992

Modifications of Standard 7 Governing Care and Treatment of Class Members with Mental Illness

Standard 7[1]

(7) A. Standard for Seclusion or Restraint. Patients have a right to be free from seclusion and physical restraint. Patients may be placed in seclusion or physically restrained only (a) to prevent a patient from physically injuring himself/herself or others, (b) after alternative treatment interventions have been unsuccessful or after determining that alternative treatment interventions would not be practicable, and (c) when authorized by a written order of a qualified physician[2] who is physically present and has examined the patient.

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[1] In the case of the Eufaula Adolescent Center, the plaintiffs and the defendants may agree to apply a different standard.

[2] A "qualified physician" means, for purposes of this Standard:

(a) a psychiatrist; or

(b) a licensed physician (i) who has completed a basic 10-hour review course in psychiatry, including psychopharmacology, psychopathology, psychotherapeutic interventions (e.g., the use of seclusion/restraint), interviewing, and assessment of mental status; (ii) who obtains a minimum of twenty hours of continuing medical education per year; and (iii) who has demonstrated his abilities to the satisfaction of a supervising psychiatrist, resulting in his being granted by the Medical Staff clinical privileges as a qualified physician.

The 10-hour review course shall be developed by the Department of Mental Health/Mental Retardation in consultation with consumers and ex-patients.

No order for seclusion or restraint may exceed eight hours.

B. Exceptions. Exceptions to the requirement that seclusion and restraint be implemented only pursuant to a written order of a qualified physician who is physically present and has examined the patient may be made in emergency situations when no qualified physician is available. In such situations, the use of restraint or seclusion may be implemented for up to one hour by a trained, clinically privileged, qualified registered nurse[3] to prevent a patient from physically injuring himself/herself or others, after determining that alternative treatment interventions have been unsuccessful or would not be practicable. The nurse must be physically present and evaluate the patient's physical condition to the extent that it is feasible and document the evaluation in the clinical record. A qualified physician should be notified as soon as possible after the emergency episode of seclusion or

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[3] A "qualified registered nurse" means, for purposes of this Standard:

(a) a QMHP registered nurse; or

(b) a licensed registered nurse (i) who has two years of clinical experience in an inpatient psychiatric setting under the supervision of a QMHP nurse and/or a psychiatrist; (ii) who has completed a basic 10-hour course that includes psychopharmacology, psychopathology, and psychotherapeutic interventions (e.g., the use of seclusion/restraint), interviewing, and assessment of mental status; and (iii) who obtains 20 hours of continuing professional education credits annually, 10 of which concern the treatment of persons with mental illness.

The 10-hour review course shall be developed by the Department of Mental Health/Mental Retardation in consultation with consumers and ex-patients.

restraint. A qualified physician should see the patient within four hours of the initiation of seclusion or restraint and preferably within one hour. The emergency episode of seclusion or restraint may be extended up to four hours (i.e. three hours beyond the initial one hour authorized by the qualified registered nurse) upon verbal order of a qualified physician if necessary to prevent a patient from physically injuring himself/herself or others and if, in the opinion of the qualified physician, alternative treatment interventions would be unsuccessful in preventing injury. After the emergency episode has extended for four hours, the patient must be released unless a qualified physician writes a new order for seclusion or restraint that meets the criteria in paragraph A(a-c) above. All emergency seclusion or restraint orders (including any related documentation) must be reviewed and signed by a qualified physician within twelve hours of the initial use of seclusion or restraint.

C. Orders for Seclusion or Restraint. All written orders for seclusion and restraint (including in emergency situations) shall include a clinical assessment of the patient, the alternative treatment interventions attempted, and criteria for the release of the patient which shall relate to the standard for seclusion or restraint in paragraph A above. When the criteria for release have been met or at the end of the period set out in the order (whichever occurs first), the patient must be released unless the patient is then examined by a qualified physician who writes a new order for seclusion or restraint.

D. Management of Patients in Seclusion or Restraint. A documented observation shall be made of a

patient in restraint or seclusion at least every fifteen minutes. The person making the observation shall be made aware of and shall take account of any special medical concerns regarding the patient. The patient must be given bathroom privileges at least every hour, must be bathed at least every twenty-four hours or more frequently if necessary, and must be provided meals and fluids on a regular basis. Vital signs shall be taken as clinically indicated. Patients in restraint shall be released for range of motion exercises as clinically indicated.

E. Additional Matters. Seclusion and restraint shall not be used as punishment or for the convenience of staff or in a manner that causes undue physical discomfort, harm, or pain to the patient. PRN orders for seclusion and restraint are prohibited.

Ricky WYATT, By and Through his aunt and legal guardian Mrs. W.C. RAWLINS, Jr., et al., Plaintiffs, Calvin Moore, et al., Plaintiff-Intervenors,

v.

Ken WALLIS, as Commissioner of Mental Health and Mental Retardation, and the State of Mental Health Officer, et al., Defendants, United States of America, et al., Amici Curiae.

Civ. A. No. 3195-N.

United States District Court, M.D. Alabama, N.D.

Sept. 22, 1986.

Peter G. Thompson, Sandra Lord, Ira Burnim, Mental Health Law Project, Washington, D.C., for plaintiffs.

R. Emmett Poundstone, III and Ricky Trawick, Alabama Department of Mental Health, Montgomery, Ala., for Horsley and Dept. of Mental Health.

Andrew J. Barrick & Mitchell W. Dale, Pamela Chen, U.S. Dept. of Justice, Civil Rights Div., Washington, D.C., for USA.

Byrd R. Latham, Patton, Latham, Legge & Cole, Athens, Ala., for Gunter, Steagall and Brassell.

Joel Kline, Washington, D.C., for Christopher Cerf, Dept. Mental Health & Horsley.

David Ferleger, Philadelphia, Pa., Reuben Cook, Edward Stevens, Victoria Farr and Donald Tipper, Ala. Disabilities Advocacy Program, Tuscaloosa, Ala., for intervenors Martin, et al.

Algert Agricola, Mark Montiel, and David Byrne, Montgomery, Ala., for State defendants.

R. David Christy, Montgomery, Ala., for Horsley.

ORDER

MYRON H. THOMPSON, Chief Judge.

This class action lawsuit involving the Mental Health and Mental Retardation System of the State of Alabama is now before the court on the parties' proposed settlement of the latest round of litigation. A hearing was held on the settlement on August 22, 1986. For reasons that follow, the court has concluded that the settlement is due to be approved.

I. BACKGROUND

A brief review of the sixteen-year history of this case will aid in the court's discussion of its decision. This suit began on October 23, 1970, with a complaint filed in this court alleging that staff reductions at Bryce Hospital, the state-run institution for the mentally ill at Tuscaloosa, Alabama, had deprived the patients of rights under state and federal law.[1] On March 12, 1971, in response to a request for preliminary relief, the Honorable Frank M. Johnson, Jr., then chief district judge, found that the

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[1] While this suit also initially involved a claim that employees at Bryce had been deprived of certain rights as a result of significant staff reductions, that aspect of the litigation was later withdrawn and never became relevant to the proceedings involving the rights of committed residents. *See Wyatt v. Stickney*, 325 F.Supp. 781, 782 n. 1 (M.D.Ala.1971).

patients who had been involuntarily committed to Bryce Hospital because of mental illness were being deprived of their constitutional right "to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." *Wyatt v. Stickney*, 325 F.Supp. 781, 784 (M.D.Ala.1971).

On August 22, 1971, the court granted the plaintiffs' request to enlarge the plaintiff class to include patients involuntarily committed at Searcy Hospital, the state's other mental illness institution, and at Partlow State School and Hospital, the state's institution for the mentally retarded. On December 10, 1971, the court entered another order which identified numerous factors which contributed to the degrading and dehumanizing environment at Bryce Hospital. *Wyatt v. Stickney*, 334 F.Supp. 1341, 1343-44 (M.D.Ala.1971). The court additionally found on the basis of preliminary evidence relating to Searcy and Partlow that there were "strong indications" that conditions at these institutions were no better than at Bryce. *Id.* Finding that the defendants had failed to submit an adequate proposal for the "minimum medical and constitutional standards for the operation of these institutions," 334 F.Supp. at 1344, the court ruled that it would hold another hearing to allow the parties and amici to present proposed minimum standards. The court cautioned that the "plaintiffs' rights are present ones, and they must be not only declared but secured at the earliest practicable date." *Id.*

In response to the court's order, the plaintiffs, defendants, and amici jointly proposed certain minimum standards for adequate treatment and habilitation of the

residents at the state's mental illness and mental retardation facilities. In addition, the parties independently proposed other standards to be considered in determining the minimum constitutional standards. After hearing testimony from the foremost mental health and mental retardation authorities in the United States, the court on April 13, 1972, entered orders establishing minimum constitutional standards for adequate care and treatment of the mentally ill and mentally retarded. *Wyatt v. Stickney*, 344 F.Supp. 373, 379-86 (mental illness) (M.D.Ala.1972); *Wyatt v. Stickney*, 344 F.Supp. 387, 392, 394-407 (M.D.Ala.1972) (mental retardation).

Litigation began again in this case in December 1975, when the court allowed the parties to reopen discovery to determine whether the defendants had complied with the standards set forth in the 1972 orders. In June 1977, the plaintiffs and amici curiae filed a motion for further relief and requested, among other things, that the court appoint a special master or receiver to assure the defendants' compliance with the 1972 orders. Later, in a separate petition Governor James advised the court that "the Alabama mental health system is in a distress situation" and that achievement "of an effective mental health system maintained and operated in the interest of the safety and welfare of the patients and indeed, all of the citizens of this state, require[s] the assertion of the extraordinary equitable powers of this Court." The Governor then requested that the court appoint him receiver of the Alabama Mental Health and Mental Retardation System. On January 2, 1980, Governor James submitted a proposed plan of compliance, which provided for "complete compliance with the 1972 Court Order within 18 months,

except new physical plant construction or major renovation." Then, on January 15, 1980, upon consideration of the nominations submitted by all the parties and the plan of compliance submitted by Governor James, the court appointed Governor James as temporary receiver of the state system.

The current phase of this litigation began on March 9, 1981, when the plaintiffs moved for the provision of sufficient funds for compliance with this court's orders and Governor James's plan of implementation. Shortly thereafter, on May 18, 1981, Governor James and the Commissioner of Mental Health and Retardation moved for modification of this court's 1972 standards and orders. Then, on August 25, 1981, Governor James moved for termination of the receivership, and on January 4, 1982, the plaintiffs moved to remove and replace Governor James as receiver. During the period of time in which parties filed amendments and responses to these various motions, discovery was gradually reopened.

On January 14, 1983, James's term as governor ended and he resigned as receiver. On February 1, 1983, the court appointed a non-state official as receiver. The defendants appealed to, and obtained a stay of the appointment from, the Eleventh Circuit. In response to the stay, the court appointed Ken Wallis, the new governor's legal advisor, as receiver.

II. THE SETTLEMENT

In July 1986, the parties submitted a proposed settlement of the last round of litigation regarding the Alabama Mental Health and Mental Retardation System. The

settlement provides for the dissolution of not only the receivership but also the Office of Court Monitor, an office specifically created to monitor on a daily basis the defendants' implementation of the court's orders and standards. It also provides for the denial of not only the defendants' motions to vacate the prior standards and orders of the court and terminate this litigation, but also the plaintiffs' motions for judicially ordered funding and appointment of an independent receiver. The settlement states that the prior orders and standards issued by the court regarding the obligations of the state system are to remain in full force and effect, and that the defendants are "to continue to make substantial progress in achieving compliance with the orders and standards."

The settlement also requires that the defendants make reasonable efforts to achieve and maintain full accreditation of the state's mental health facilities by the Joint Commission on the Accreditation of Hospitals, and that they make reasonable efforts to achieve and maintain full certification of the state's mental retardation facilities under Title XIX of the Social Security Act. The defendants are also required to continue to make substantial progress in placing members of the plaintiff class in community facilities and programs and to take all reasonable steps to implement various plans to be filed later with the court under seal, including plans for the physical improvement of Bryce Hospital and for the construction of community facilities.

The settlement also requires that the parties establish a patient advocate program to help protect the rights of the plaintiff class and a quality assurance program to monitor and assure the quality of care provided to

patients. The advocacy and quality assurance programs are to be operated by and within the Mental Health and Mental Retardation System.

The parties are also required to establish a process by which plaintiffs' counsel would be apprised of the defendants' compliance with the settlement. The settlement also requires that the defendants pay the plaintiffs their costs and reasonable attorney fees.

Finally, the settlement provides that should the defendants fail to comply with significant provisions in the settlement – including substantial progress in achieving and maintaining compliance with the prior orders and standards of the court, in placing members of the plaintiff class in community facilities and programs, and in achieving and maintaining full accreditation for the mental health facilities and full certification for the mental retardation facilities – the court will entertain requests to reactivate its active supervision of the state Mental Health and Mental Retardation System.

After notice of the settlement was given to the public, the court held a hearing on the settlement on August 22, 1986. Both before and during the hearing, the court received a number of objections to the settlement.

III. THE LAW

Courts have repeatedly stated that voluntary settlement is the preferred means of resolving class action disputes. *See, e.g., Bennett v. Behring Corp.*, 737 F.2d 982, 986 (11th Cir.1984); *Holmes v. Continental Can Co.*, 706 F.2d 1144, 1147 (11th Cir.1983); *Pettway v. American Cast Iron*

Pipe Co., 576 F.2d 1157, 1214 (5th Cir.1978), *cert. denied*, 439 U.S. 1115, 99 S.Ct. 1020 (1979); *Johnson v. Montgomery County Sheriff's Department*, 604 F.Supp. 1346 (M.D.Ala.1985); *Lurns v. Russell Corporation*, 604 F.Supp. 1335 (M.D.Ala.1984). However, "[b]ecause of the potential for a collusive settlement, a sellout of a highly meritorious claim, or a settlement that ignores the interests of minority class members, the district judge has a heavy duty to ensure that any settlement is 'fair, reasonable and adequate'. . . . " *Piambino v. Bailey*, 757 F.2d 1112, 1139 (11th Cir.1985), *cert. denied*, ___ U.S. ___, 106 S.Ct. 2889 (1986). The district judge also has a duty to ensure that the settlement is not illegal or against public policy. *United States v. City of Alexandria*, 614 F.2d 1358, 1362 (5th Cir.1980).[2] Furthermore, a court should be even more circumspect about accepting a settlement where, as here, many members of the plaintiff class are not themselves capable of assessing the settlement and voicing their views on whether it is fair, reasonable and adequate, and the court must therefore rely on comments from such secondary sources as public interest groups and organizations.

In considering these concerns, a court has broad discretion to accept a settlement. *Bennett*, 737 F.2d at 986. The converse is not true, however; a court does not have such broad discretion to reject a settlement. The law in

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[2] The law of the former Fifth Circuit prior to October 1, 1981, is binding on the New Eleventh Circuit. *Bonner v. City of Prichard, Alabama*, 661 F.2d 1206 (1981) (en banc).

this circuit is that "[t]he public policy in favor of voluntary settlements, which is fostered by a deferential standard of appellate review, is defeated by a standard which would allow trial courts to impose their views of reasonableness, subject only to highly deferential 'abuse of discretion' review, on settlements. . . . " *City of Alexandria*, 614 F.2d at 1362. It clearly appears that the law does not countenance "that individual federal judges should have almost unchallengeable power" to reject settlements. *Id.* This is particularly true where all the named parties and their counsel favor the settlement and there is no evidence of fraud, collusion or the like among counsel, *Cotton v. Hinton*, 559 F.2d at 1326, 1331 (5th Cir.1977), and there are no diverging interests among definable groups within the class, such as would possibly raise a conflict within the class. *Pettway*, 576 F.2d at 1216. Under such circumstances, a court simply may not freely substitute its own judgment for that of counsel as to whether the settlement is adequate, fair, and reasonable. *Pettway, supra; Cotton, supra; see also Armstrong v. Board of School Directors*, 616 F.2d 305, 315 (7th Cir.1980) ("Judges should not substitute their own judgment as to optimal settlement terms for the judgment of the litigants and their counsel").

To be sure, the settlement here offers both substantial pluses and substantial minuses for the plaintiff class. However, under the heightened standard of this circuit, this court cannot reject the settlement and must accept it.

The first significant plus is that the settlement preserves the integrity and force of the court's prior historic standards and orders. This settlement provision may not appear at first blush to be that significant and substantial,

but it is. After the initiation of the last round of litigation, which was in substantial part a vigorous frontal attack by the defendants on the continued validity of the court's prior standards and orders, a number of appellate decisions cast substantial doubt on whether these standards and orders could withstand the challenge. *See, e.g., Youngberg v. Romeo,* 457 U.S. 307, 102 S.Ct. 2452 (1982); *Newman v. Graddick,* 740 F.2d 1513 (11th Cir.1984). As both the plaintiffs and the defendants now correctly observe, the incorporation of these standards into a settlement makes these standards and orders unsusceptible to challenges because of present and future changes in the law. Without question, one of the most significant things bargained away by the defendants in order to secure the plaintiffs' approval of the settlement is the defendants' vigorously asserted and often repeated contention that the court's prior standards and orders are always subject to attack because of present and future changes in the law.

The settlement does not stop with the preservation of the court's prior standards and orders, however. It also requires that the defendants secure and maintain accreditation by the Joint Commission on Hospital Accreditation and certification under Title XIX of the Social Security Act. But perhaps most importantly, the settlement achieves something the plaintiffs were unable to achieve in the past: it substantially broadens the focus of the litigation to include community placement and requires that the defendants make substantial progress in placing people in the community. Indeed, part of the capital construction program contemplated by the settlement includes the construction of hundreds of community beds throughout the state. Generally, community placement is

preferred to institutional placement, and at present there is a great dearth of community facilities throughout the state.

According to a number of objectors, a significant minus is the termination of the receivership. The court disagrees with this contention. First, the court doubts whether under the present law and facts the continuation of the receivership could be justified. But second and most importantly, the receivership was never a true receivership; the receiver was never independent of the defendants, and, while specially empowered to bring about immediate and substantial changes not otherwise obtainable, the receiver never exercised these powers. The receivership, in effect, merely shifted the responsibility for the Mental Health and Mental Retardation System from one state official or group of officials to another state official. The creation of the receivership was more an act of significance than substance, and with time it has lost even its significance.

Another significant minus, according to a number of objectors, is the dissolution of the Monitor's Office. The court is deeply troubled by this provision in the settlement and is concerned that, in view of past friction between the monitor and the defendants, the provision may reflect an unsavory retaliatory sentiment, an effort by the defendants "to get the last lick." Indeed, the monitor and his staff have over the years served as an independent check on whether the defendants were taking all reasonable steps to bring the Mental Health and Mental Retardation System into compliance with the standards and orders of the court. The monitor and his staff have

performed this task admirably, always with vigor, objectivity, and fairness. Admittedly, the settlement does provide for a patient advocate program and a quality assurance program. While these two programs will in substantial measure take over the responsibilities of the monitor, they will do so under the control of the defendants; they will lack the independence the monitor had. Nonetheless, the court's concerns, though serious, do not warrant disapproval of the settlement under the standards of this circuit for accepting and rejecting settlements. *See Halderman v. Pennhurst State School and Hospital*, 610 F.Supp. 1221, 1231 (E.D.P.1985) (court approved settlement containing monitoring procedures that were less effective than court-ordered procedures).

Another troubling concern for the court and many objectors is that the settlement provides no specific deadlines or certainty of funds for compliance. Indeed, the settlement allows the defendants until December 1, 1986, to submit future plans for the state system, and merely enjoins them to take "reasonable steps" to implement the plans.

Admittedly, on the one hand, there has been in this lawsuit a trail of broken promises of when there would be full compliance with the standards and orders of this court. On the other hand, one cannot question that since this lawsuit began there has been substantial and dramatic improvement in the Alabama Mental Health and Mental Retardation System. Counsel for the plaintiffs therefore correctly point out that past experience with the court-ordered deadlines has brought substantial compliance but not timely full compliance. Counsel for both plaintiffs and defendants ask that the court now try the

approach offered by the settlement. While they admit that they cannot assure the court that the settlement will bring about early full compliance, they believe that, in light of the present state of the law and the present political climate in the state, the settlement is more likely to do so than a new set of specific deadlines. The court cannot say that counsel's belief is unreasonable or unfounded.

Finally, a number of objectors to the settlement strongly question whether the court should terminate its active supervision of the Mental Health and Mental Retardation System when a number of state public service programs, including the Mental Health and Mental Retardation System, are threatened with a severe shortage of state funding. Counsel for plaintiffs correctly observe that if the point is reached where lack of funding actually threatens or impedes the ability of the defendants to continue in their efforts to reach and maintain full compliance with standards and orders of the court, the plaintiffs are still authorized by the settlement to request appropriate relief from the court. That relief would include reactivation of active court supervision of the system, if warranted.

IV.

The court is convinced that the settlement here is a mixed bag, as are all settlements; courts have repeatedly emphasized that "[c]ompromise is the essence of settlement," and part of any settlement is "the yielding of absolutes." *Cotton*, 559 F.2d at 1130. But more importantly, under the standards previously articulated for

accepting and rejecting settlements, the court must conclude, in the absence of fraud or collusion or a conflict within the class, that overall the settlement is fair, adequate and reasonable. While admittedly the settlement contains troubling provisions, it also contains significant and substantial rewards for the plaintiff class. Therefore, viewing the settlement not in fragments but "as a whole" as the court must, *Cotton*, 559 F.2d at 1326, the court will approve the settlement. *See Halderman v. Pennhurst State School and Hospital*, 610 F.Supp. 1221 (E.D.Pa.1985) (court approved "imperfect" settlement of mental retardation case).

Accordingly, it is the ORDER, JUDGMENT, and DECREE of the court that the settlement entered into and submitted by the parties is approved and adopted by the court.

CONSENT DECREE

The parties in this action have settled the outstanding disputed matters in this case and have consented to the entry of an injunction with the following terms. The Court finds that the parties' settlement is reasonable and fair. It is therefore ORDERED, ADJUDGED, and DECREED that:

1. All pending motions be and are hereby DENIED as moot.

2. The Court's active supervision of the state's mental health and mental retardation system be and is hereby TERMINATED.

3. The Court's prior orders placing the Alabama mental health and mental retardation system in receivership be and are hereby VACATED.

4. The obligations and powers of the Court Monitor shall be TERMINATED as of October 1, 1986, and the monitorship shall at that time end. The Court and all parties express their heartfelt thanks for the work done by Dr. Roger Hildreth and his staff.

5. All defendants except for the defendant Commissioner of Mental Health and Mental Retardation and the defendant institutional directors be and are hereby DISMISSED as parties in this action.

6. The prior orders of, and standards issued by, this Court regarding the obligations of the state's mental health and mental retardation system shall REMAIN IN EFFECT.

7. The Court and the parties recognize that the defendants have made substantial and significant progress in attaining compliance with the orders and standards issued by this Court; however, the Court and the parties also recognize that the state's mental health and mental retardation system is still not in compliance with portions of these orders and standards, including those orders and standards compliance with which would require significant capital expenditures to improve the physical conditions in which patients at Bryce Hospital are served. Accordingly, the defendants are hereby ENJOINED to continue to make substantial progress in achieving compliance with the orders and standards referred to in paragraph 6 above.

8. The defendants have commendably chosen to seek and maintain accreditation from the Joint Commission on Hospitals of the state's mental illness facilities and certification under Title XIX of the Social Security Act of the state's mental retardation facilities as a means of achieving progress toward compliance with the prior orders of this Court. By agreement of the parties, the defendants are hereby ENJOINED to make all reasonable efforts to achieve full accreditation of Alabama's mental health facilities by the Joint Commission on the Accreditation of Hospitals and full certification of Alabama's mental retardation facilities under Title XIX of the Social Security Act – and once attained, to continue to maintain such accreditation and certification.

9. The defendants be and are hereby ENJOINED to continue to make substantial progress in placing members of the plaintiff class in community facilities and programs. In this regard, the Court commends the defendants for their plans to raise capital funds to provide needed community placements and services; the defendants have represented that they will implement their plans as soon as is feasible.

10. The Court has agreed to the issuance of this Decree based not only on the commendable progress made to date towards achieving compliance with the prior orders of this Court but also on representations made by the defendants concerning the future plans of the state's mental health and mental retardation system. Documents reflecting these representations will be filed with the Clerk on or before December 1, 1986, and, with the exception of defendants' plan for capital spending, shall be available to the public. The defendants' plan for

capital spending shall be filed and maintained under seal until presented to the Legislature. The defendants are ENJOINED to take all reasonable steps to implement the plans described in these documents.

11. The private plaintiffs and the defendants be and are hereby ENJOINED to cooperate to establish:

a. A process by which the private plaintiffs' counsel will be apprised of the progress made by the defendants toward the ends described in paragraphs 7, 8, and 9 above; and

b. A process by which the defendants will continue to receive input from independent experts concerning means of achieving the ends described in paragraphs 7, 8, and 9 above;

c. A patient advocate system, operated within and by the Alabama Department of Mental Health and Mental Retardation, to help protect the rights of the plaintiff class; and

d. A quality assurance system operated by the central office of the Alabama Department of Mental Health and Retardation to monitor and assure the quality of care provided by the Department.

12. The parties be and are hereby PLACED ON NOTICE that the Court will entertain requests to reassert its active supervision of the Alabama mental health and mental retardation system if defendants do not continue to make substantial progress toward the ends described in paragraphs 7, 8, and 9 above.

13. It is RECOGNIZED that defendants may, after October 1, 1988, move for a finding that they have met their obligations under this Consent Order.

14. The defendants be and are hereby ENJOINED to pay the private plaintiffs their costs and a reasonable attorneys' fee for legal work done in connection with all pending motions and the negotiation of this Decree. The private plaintiffs and the defendants should seek to negotiate the amount of costs and fees to be paid to plaintiffs. If after 90 days from the date of this Decree the parties have not arrived at an agreement, the plaintiffs shall have an additional 90 days within which to file a motion for costs and fees.

Ricky WYATT, By and Through his aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., Plaintiffs,

v.

Charles ADERHOLT, as Commissioner of Mental Health and The State of Alabama Mental Health Officer, et al.,
Defendants, United States of America et al.,
Amici Curiae.

Civ. A. No. 3195-N (B).
United States District Court,
M.D. Alabama, N.D.
Dec. 20, 1973.

George W. Dean, Jr., Destin, Fla., Jack Drake, Drake, Knowles & Still, Tuscaloosa, Ala., for plaintiffs.

William J. Baxley, Atty. Gen., State of Alabama, Robert L. Humphries, Asst. Atty. Gen., State of Alabama, Montgomery, Ala., for defendants.

Ira DeMent, U. S. Atty., Middle District of Alabama, Kenneth E. Vines, Asst. U. S. Atty., Middle District of Alabama, Montgomery, Ala., Michael S. Lottman, and Diane S. Dorfman, Civil Rights Div., U. S. Dept. of Justice, Washington, D. C., for amicus the United States.

Charles R. Halpern, Washington, D. C., Paul Friedman, and Bruce J. Ennis (Mental Health Law Project), New York City, James F. Fitzpatrick and Jeffrey D. Bauman, Arnold & Porter, Washington, D. C., for amici American Orthopsychiatric Assn., American Psychological Assn., and American Civil Liberties Union.

Before RIVES, Circuit Judge, JOHNSON, Chief District Judge, and VARNER, District Judge.

OPINION AND ORDER

PER CURIAM.

The plaintiffs filed on July 25, 1973 a document styled "Amended Complaint or Alternatively Motion for Further Relief," in which they prayed for an injunction enjoining the enforcement of the following statute of the State of Alabama:

> "§ 243. *Treatment of inmates prescribed by assistant.* – The assistant with the advice and consent of the superintendent shall prescribe for the treatment of the inmates of the home, and if after consultation with the superintendent, they deem it advisable they are hereby authorized and empowered to sterilize any inmate."

Tit. 45, Code of Ala., Recomp.1958.

Pursuant to 28 U.S.C. § 2281, this three-judge court was appointed to decide whether an injunction should be granted restraining the enforcement of that statute.

The defendants insist that they have never relied on that statute as authorization for performing sterilization operations, and the uncontradicted evidence so shows.

The position taken by the United States is indicated by footnote 6 to its brief:

> "The fact that defendants contend, and the evidence tends to show, that the challenged statute has not been used as a basis for sterilization of Partlow residents raises a question as to whether, without an imminent threat of enforcement, the constitutionality of a State statute may be adjudicated, or its enforcement enjoined, by a Federal court. *Poe v. Ullman*, 367 U.S. 497 [81

> S.Ct. 1752, 6 L.Ed.2d 989] (1961). However, the instant case presents special circumstances which would distinguish it from the factual situation in *Poe*. Members of the plaintiff class are confined at Partlow; sterilizations are being performed, at a gradually increasing rate; and though it is claimed that the statute is not the basis for the Partlow procedures, no other authority is cited. Moreover, in requesting the Court to promulgate standards which must be followed in future sterilizations, the plaintiffs in effect are seeking to enjoin the operation of the challenged statute, since the proposed standards and the statute are necessarily in conflict."

An injunction is not necessary, but by way of extreme precaution to protect the inmates of Partlow State School and Hospital, we do formally declare that the statute is clearly and obviously unconstitutional. The sterilization *vel non* of mentally retarded inmates cannot be left to the unfettered discretion of any two officials or individuals. Further, the statute contains no provision for notice, hearing or any other procedural safeguard. *Cf. Buck v. Bell*, 1927, 274 U.S. 200, 207, 47 S.Ct. 584, 71 L.Ed. 1000; In re Opinion of the Justices, 230 Ala. 543, 162 So. 123.

With this declaration of the unconstitutionality of the Alabama statute, the three-judge court has performed its essential function. It is therefore ordered and adjudged that the three-judge district court be and the same is hereby dissolved.

Ricky WYATT, By and Through his aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., Plaintiffs,

v.

Charles ADERHOLT, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, et al., Defendants, United States of America et al., Amici Curiae.

Civ. A. No. 3195-N (B).
United States District Court,
M.D. Alabama, N.D.
Jan. 8, 1974.

ORDER

JOHNSON, Chief Judge.

On December 20, 1973, the three-judge court in *Wyatt v. Aderholt, D.C.*, 368 F.Supp. 1382, declared that Tit. 45, § 243, Code of Alabama, is unconstitutional. As a consequence of that action, the three-judge feature of this case is now complete and that court has been dissolved. However, since it appears that sterilization continues to be performed in certain instances by the state health authorities, it is necessary that this Court promulgate adequate standards and procedural safeguards to insure that all future sterilizations be performed only where the full panoply of constitutional protections has been accorded to the individuals involved. Accordingly, it is ordered that the following standards be and they are hereby adopted and ordered implemented from this date for the sterilization of mentally retarded residents of the state retardation facilities:

1. (a) "Sterilization," as used in these standards, means any medical or surgical operation or procedure which results in a patient's permanent inability to reproduce.

(b) A determination that a proposed sterilization is in the best interest of a resident, as referred to in these standards, must include a determination that no temporary measure for birth control or contraception will adequately meet the needs of such resident, and shall not be made on the basis of institutional convenience or purely administrative considerations.

2. No resident who has not attained the chronological age of 21 years shall be sterilized except in cases of medical necessity as determined in accordance with the procedures set forth below. No other resident shall be sterilized except in accordance with procedures set forth below.

3. No resident shall be sterilized unless such resident has consented in writing to such sterilization. Except as set forth below, such consent must be informed, in that it is (a) based upon an understanding of the nature and consequences of sterilization, (b) given by a person competent to make such a decision, and (c) wholly voluntary and free from any coercion, express or implied. It shall be the responsibility of the Director of the Partlow State School (with the assistance of employees or officials designated by him) to provide the resident with complete information concerning the nature and consequences of sterilization, to assist the resident in comprehending such information, and to identify any barriers to such comprehension.

4. The Director shall prepare a report evaluating the resident's understanding of the proposed sterilization and describing the steps taken to inform the resident of the nature and consequences of sterilization. If the resident has been determined by a court of competent jurisdiction to be legally incompetent, or if the Director cannot certify without reservation that the resident understands the nature and consequences of sterilization, the sterilization shall not be performed unless (a) the Director sets forth reasonable grounds for believing that such sterilization is in the best interest of the resident; (b) the Review Committee described below approves such sterilization; and (c) it is determined by a court of competent jurisdiction that such sterilization is in the best interest of the resident.

5. No sterilization shall be performed without the prior approval of a Review Committee formed in accordance with this paragraph. The Review Committee shall consist of five members, and shall be selected by the Partlow Human Rights Committee and approved by the Court. The members shall be so selected that the Committee will be competent to deal with the medical, legal, social, and ethical issues involved in sterilization; to this end, at least one member shall be a licensed physician, at least one shall be a licensed attorney, at least two shall be women, at least two shall be minority group members, and at least one shall be a resident of the Partlow State School (the foregoing categories are not mutually exclusive). No member shall be an officer, employee, or agent of the Partlow State School, nor may any member be otherwise involved in the proposed sterilization.

Any fees or costs incurred by reason of services performed by the Review Committee, including reasonable fees for the physician and the attorney, shall be paid by the Alabama Department of Mental Health upon a certification of reasonableness by the Partlow Human Rights Committee.

6. Prior to approving the proposed sterilization of any resident, the Review Committee shall:

(a) Review appropriate medical, social, and psychological information concerning the resident, including the report of the Director prepared pursuant to paragraph 4;

(b) Interview the resident to be sterilized;

(c) Interview concerned individuals, relatives, and others who in its judgment will contribute pertinent information;

(d) Determine whether the resident has given his or her informed consent to the sterilization, or, if the resident is legally incompetent or the Director cannot certify without reservation that the resident understands the nature and consequences of sterilization, whether the resident has formed, without coercion, a genuine desire to be sterilized. In making such determination, the Review Committee shall take into consideration, *inter alia*, the report prepared by the Director pursuant to paragraph 4 and the interview required by paragraph 6(b).

(e) Determine whether the proposed sterilization is in the best interest of the resident.

If the Review Committee does not reach an affirmative determination as to the matters set forth in paragraphs 6(d) and (e), it shall not approve the proposed sterilization. Any doubts as to such matters shall be resolved against proceeding with sterilization.

7. Residents shall be represented throughout all the procedures described above by legal counsel appointed by the Review Committee from a list of such counsel drawn up by the Partlow Human Rights Committee and approved by the Court. Such counsel shall, *inter alia*, ensure that all considerations militating against the proposed sterilization have been adequately explored and resolved. No such counsel shall be an officer, employee, or agent of the Partlow State School, nor may such counsel be otherwise involved in the proposed sterilization.

8. The Review Committee shall maintain written records of its determinations and the reasons therefor, with supporting documentation. Such records shall be available for examination by the Partlow Human Rights Committee, the Court, and counsel of record in this cause. The Review Committee shall report in writing at least monthly to the Human Rights Committee, the Court, and counsel of record in this cause as to the number and nature of sterilizations approved and disapproved, the procedures employed in approving or disapproving such sterilizations, the reason for determining that such sterilizations were in the best interest of the residents involved, the number and nature of proposed sterilizations referred to courts of competent jurisdiction, and all other relevant information. The identity of residents sterilized or to be sterilized shall not be disclosed in such reports.

9. There shall be no coercion in any form with regard to sterilization of any resident. Consent to sterilization shall not be made a condition for receiving any form of public assistance, nor may it be a prerequisite for any other health or social service, or for admission to or release from the Partlow State School. Any individual having knowledge of coercion of any resident with regard to sterilization shall immediately bring such matter to the attention of the Partlow Human Rights Committee, the Court, or counsel of record in this cause.

It is further ordered that the defendants, their agents, employees and those acting in concert with them be and each is hereby enjoined from failing to implement the standards hereinabove set out for the sterilization of mentally retarded residents of the Alabama retardation facilities.

Ricky WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., et al., for themselves jointly and severally and for all others similarly situated, Plaintiffs,

v.

Dr. Stonewall B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, et al., Defendants, United States of America et al., Amici Curiae.

Civ. A. No. 3195-N.
United States District Court,
M. D. Alabama, N. D.
April 13, 1972.

George W. Dean, Jr., Destin, Fla., Jack Drake (Drake, Knowles & Still), Tuscaloosa, Ala., Reber F. Boult, Jr., Atlanta, Ga., Morton Birnbaum, Brooklyn, N. Y., for plaintiffs.

William J. Baxley, Atty. Gen., of Alabama, J. Jerry Wood, Asst. Atty. Gen., of Alabama, Montgomery, Ala., John J. Coleman, Special Asst. Atty. Gen., of Alabama, Birmingham, Ala., for defendants.

Ira DeMent, U. S. Atty., Middle District of Alabama, Montgomery, Ala., Robert H. Johnson and David J. W. Vanderhoof, Civil Rights Division, U. S. Dept. of Justice, Washington, D. C., Cleveland Thornton, Special Asst. U.S. Atty., Middle District of Alabama, Montgomery, Ala., for the United States amici curiae.

Charles R. Halpern (Center for Law & Social Policy), James F. Fitzpatrick, Stephen M. Sacks, and Jeffrey D. Bauman (Arnold & Porter) Washington, D. C., Bruce Ennis (American Civil Liberties Union), New York City, Stanley Herr (NLADA National Law Office), Washington,

D. C., Shelley Mercer (National Health and Environmental Program, School of Law, UCLA), Los Angeles, Cal., Paul Friedman (Center for Law and Social Policy), Washington, D. C., for other amici curiae.

ORDER AND DECREE

JOHNSON, Chief Judge.

This class action originally was filed on October 23, 1970, in behalf of patients involuntarily confined for mental treatment purposes at Bryce Hospital, Tuscaloosa, Alabama. On March 12, 1971, in a formal opinion and decree, this Court held that these involuntarily committed patients "unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." The Court further held that patients at Bryce were being denied their right to treatment and that defendants, per their request, would be allowed six months in which to raise the level of care at Bryce to the constitutionally required minimum. *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala.1971). In this decree, the Court ordered defendants to file reports defining the mission and functions of Bryce Hospital, specifying the objective and subjective standards required to furnish adequate care to the treatable mentally ill and detailing the hospital's progress toward the implementation of minimum constitutional standards. Subsequent to this order, plaintiffs, by motion to amend granted August 12, 1971, enlarged their class to include patients involuntarily

confined for mental treatment at Searcy Hospital[1] and at Partlow State School and Hospital for the mentally retarded.[2]

On September 23, 1971, defendants filed their final report, from which this Court concluded on December 10, 1971, 334 F.Supp. 1341, that defendants had failed to promulgate and implement a treatment program satisfying minimum medical and constitutional requisites. Generally, the Court found that defendants' treatment program was deficient in three fundamental areas. It failed to provide: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. More specifically, the Court found that many conditions, such as nontherapeutic, uncompensated work assignments, and the absence of any semblance of privacy, constituted dehumanizing factors contributing to

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[1] Searcy Hospital, located in Mount Vernon, Alabama, is also a State institution designed to treat the mentally ill. On September 2, 1971, defendants answered plaintiffs' amended complaint, as it related to Searcy, with the following language:

> "Defendants agree to be bound by the objective and subjective standards ultimately ordered by this Honorable Court in this cause at both Bryce and Searcy."

This answer obviated the necessity for this Court's holding a formal hearing on the conditions currently existing at Searcy. Nevertheless, the evidence in the record relative to Searcy reflects that the conditions at that institution are no better than those at Bryce.

[2] The aspect of the case relating to Partlow State School and Hospital for the mentally retarded will be considered by the Court in a decree separate from the present one.

the degeneration of the patients' self-esteem. The physical facilities at Bryce were overcrowded and plagued by fire and other emergency hazards. The Court found also that most staff members were poorly trained and that staffing ratios were so inadequate as to render the administration of effective treatment impossible. The Court concluded, therefore, that whatever treatment was provided at Bryce was grossly deficient and failed to satisfy minimum medical and constitutional standards. Based upon this conclusion, the Court ordered that a formal hearing be held at which the parties and amici[3] would have the opportunity to submit proposed standards for constitutionally adequate treatment and to present expert testimony in support of their proposals.

Pursuant to this order, a hearing was held at which the foremost authorities on mental health in the United States appeared and testified as to the minimum medical and constitutional requisites for public institutions, such as Bryce and Searcy, designed to treat the mentally ill. At this hearing, the parties and amici submitted their proposed standards, and now have filed briefs in support of them.[4] Moreover, the parties and amici have stipulated to

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[3] The amici in this case, including the United States of America, the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency, have performed exemplary service for which this Court is indeed grateful.

[4] On March 15, 1972, after the hearing in this case, plaintiffs filed a motion for further relief. This motion served, among other things, to renew an earlier motion, filed by plaintiffs on September 1, 1971, and subsequently denied by the Court, to

a broad spectrum of conditions they feel are mandatory for a constitutionally acceptable minimum treatment

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add additional parties. That earlier motion asked that the Court add:

> "Agnes Baggett, as Treasurer of the State of Alabama; Roy W. Sanders, as Comptroller of the State of Alabama; Ruben King, as Commissioner of the Alabama Department of Pensions and Security, George C. Wallace as Chairman of the Alabama State Board of Pensions and Security, and James J. Bailey as a member of the Alabama State Board of Pensions and Security and as representative of all other members of the Alabama State Board of Pensions and Security; J. Stanley Frazer, as Director of the Alabama State Personnel Board and Ralph W. Adams, as a member of the Alabama State Personnel Board and as representative of all other members of the Alabama State Personnel Board."

The motion of September 1, 1971, also sought an injunction against the treasurer and the comptroller of the State paying out State funds for "non-essential functions" of the State until enough funds were available to provide adequately for the financial needs of the Alabama State Mental Health Board.

In their motion of March 15, 1972, plaintiffs asked that, in addition to the above-named State officials and agencies, the Court add as parties to this litigation Dr. LeRoy Brown, State Superintendent of Education and Lt. Governor Jere Beasley, State Senator Pierre Pelham and State Representative Sage Lyons, as representatives of the Alabama Legislature. The motion of March 15, 1972, also requested the Court to appoint a master, to appoint a human rights committee and a professional advisory committee, to order the sale of defendant Mental Health Board's land holdings and other assets to raise funds for the operation of Alabama's mental health institutions, to

program. This Court, having considered the evidence in the case, as well as the briefs, proposed standards and stipulations of the parties, has concluded that the standards set out in Appendix A to this decree are medical and constitutional minimums. Consequently, the Court will order their implementation.[5] In so ordering, however, the Court emphasizes that these standards are, indeed, both medical and constitutional minimums and should be viewed as such. The Court urges that once this order is effectuated, defendants not become complacent and self-satisfied. Rather, they should dedicate themselves to providing physical conditions and treatment programs at Alabama's mental institutions that substantially exceed medical and constitutional minimums.

In addition to asking that their proposed standards be effectuated, plaintiffs and amici have requested other relief designed to guarantee the provision of constitutional and humane treatment. Pursuant to one such

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enjoin the construction of any physical facilities by the Mental Health Board and to enjoin the commitment of any more patients to Bryce and Searcy until such time as adequate treatment is supplied in those hospitals.

[5] In addition to the standards detailed in this order, it is appropriate that defendants comply also with the conditions, applicable to mental health institutions, necessary to qualify Alabama's facilities for participation in the various programs, such as Medicare and Medicaid, funded by the United States Government. Because many of these conditions of participation have not yet been finally drafted and published, however, this Court will not at this time order that specific Government standards be implemented.

request for relief, this Court has determined that it is appropriate to order the initiation of human rights committees to function as standing committees of the Bryce and Searcy facilities. The Court will appoint the members of these committees who shall have review of all research proposals and all rehabilitation programs, to ensure that the dignity and the human rights of patients are preserved. The committees also shall advise and assist patients who allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines. At their discretion, the committees may consult appropriate, independent specialists who shall be compensated by the defendant Board. Seven members shall comprise the human rights committee for each institution, the names and addresses of whom are set forth in Appendix B to this decree. Those who serve on the committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health.

This Court will reserve ruling upon other forms of relief advocated by plaintiffs and amici, including their prayer for the appointment of a master and a professional advisory committee to oversee the implementation of the court-ordered minimum constitutional standards.[6] Federal

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[6] The Court's decision to reserve its ruling on the appointment of a master necessitates the reservation also of the Court's appointing a professional advisory committee to aid the master. Nevertheless, the Court notes that the professional mental health community in the United States has responded with enthusiasm to the proposed initiation of such a committee to assist in the upgrading of Alabama's mental health facilities.

courts are reluctant to assume control of any organization, but especially one operated by a state. This reluctance, combined with defendants' expressed intent that this order will be implemented forthwith and in good faith, causes the Court to withhold its decision on these appointments. Nevertheless, defendants, as well as the other parties and amici in this case, are placed on notice that unless defendants do comply satisfactorily with this order, the Court will be obligated to appoint a master.

Because the availability of financing may bear upon the implementation of this order, the Court is constrained to emphasize at this juncture that a failure by defendants to comply with this decree cannot be justified by a lack of operating funds. As previously established by this Court:

> "There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment-and adequate treatment from a medical standpoint – to the several thousand patients who have been civilly committed to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." *Wyatt v. Stickney,* 325 F.Supp. at 785.

From the above, it follows consistently, of course, that the unavailability of neither funds, nor staff and

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Consequently, this Court strongly recommends to defendants that they develop a professional advisory committee comprised of amenable professionals from throughout the country who are able to provide the expertise the evidence reflects is important to the successful implementation of this order.

facilities, will justify a default by defendants in the provision of suitable treatment for the mentally ill.

Despite the possibility that defendants will encounter financial difficulties in the implementation of this order, this Court has decided to reserve ruling also upon plaintiffs' motion that defendant Mental Health Board be directed to sell or encumber portions of its land holdings in order to raise funds.[7] Similarly, this Court will reserve ruling on plaintiffs' motion seeking an injunction against the treasurer and the comptroller of the State authorizing expenditures for nonessential State functions, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to the implementation of this order. The Court stresses, however, the extreme importance and the grave immediacy of the need for proper funding of the State's public mental health facilities. The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, to a lesser degree, upon the defendant Mental Health Board of Alabama. For the present time, the Court will defer to those bodies in hopes that they will proceed with the realization and understanding that what is involved in this case is not representative of ordinary governmental functions such as paving roads and maintaining buildings. Rather, what is so inextricably intertwined with how the Legislature and Mental Health Board respond to the revelations of this litigation is the very preservation of human life and dignity. Not only are

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[7] See n. 4, supra. The evidence presented in this case reflects that the land holdings and other assets of the defendant Board are extensive.

the lives of the patients currently confined at Bryce and Searcy at stake, but also at issue are the well-being and security of every citizen of Alabama. As is true in the case of any disease, no one is immune from the peril of mental illness. The problem, therefore, cannot be over-emphasized and a prompt response from the Legislature, the Mental Health Board and other responsible State officials, is imperative.

In the event, though, that the Legislature fails to satisfy its well-defined constitutional obligation, and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master, to ensure that proper funding is realized[8] and that adequate treatment is available for the mentally ill of Alabama.

This Court now must consider that aspect of plaintiffs' motion of March 15, 1972, seeking an injunction against further commitments to Bryce and Searcy until such time as adequate treatment is supplied in those hospitals. Indisputably, the evidence in this case reflects

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[8] The Court understands and appreciates that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various State officials and agencies as additional parties to this litigation, and to utilize other avenues of fund raising.

that no treatment program at the Bryce-Searcy facilities approaches constitutional standards. Nevertheless, because of the alternatives to commitment commonly utilized in Alabama, as well as in other states, the Court is fearful that granting plaintiffs' request at the present time would serve only to punish and further deprive Alabama's mentally ill.

Finally, the Court has determined that this case requires the awarding of a reasonable attorneys' fee to plaintiffs' counsel. The basis for the award and the amount thereof will be considered and treated in a separate order. The fee will be charged against the defendants as a part of the court costs in this case.

To assist the Court in its determination of how to proceed henceforth, defendants will be directed to prepare and file a report within six months from the date of this decree detailing the implementation of each standard herein ordered. This report shall be comprehensive and shall include a statement of the progress made on each standard not yet completely implemented, specifying the reasons for incomplete performance. The report shall include also a statement of the financing secured since the issuance of this decree and of defendants' plans for procuring whatever additional financing might be required. Upon the basis of this report and other available information, the Court will evaluate defendants' work and, in due course, determine the appropriateness of appointing a master and of granting other requested relief.

Accordingly, it is the order, judgment and decree of this Court:

1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;

2. That human rights committees be and are hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. These committees shall have the purposes, functions, and spheres of operation previously set forth in this order. The members of the committees shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health;

3. That defendants, within six months from this date, prepare and file with this Court a report reflecting in detail the progress on the implementation of this order. This report shall be comprehensive and precise, and shall explain the reasons for incomplete performance in the event the defendants have not met a standard in its entirety. The report also shall include a financial statement and an up-to-date timetable for full compliance.

4. That the court costs incurred in this proceeding, including a reasonable attorneys' fee for plaintiffs' lawyers, be and they are hereby taxed against the defendants;

5. That jurisdiction of this cause be and the same is hereby specifically retained.

It is further ordered that ruling on plaintiffs' motion for further relief, including the appointment of a master, filed March 15, 1972, be and the same is hereby reserved.

APPENDIX A

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE TREATMENT OF THE MENTALLY ILL

I. Definitions:

a. "Hospital" – Bryce and Searcy Hospitals.

b. "Patients" – all persons who are now confined and all persons who may in the future be confined at Bryce and Searcy Hospitals pursuant to an involuntary civil commitment procedure.

c. "Qualified Mental Health Professional" –

(1) a psychiatrist with three years of residency training in psychiatry;

(2) a psychologist with a doctoral degree from an accredited program;

(3) a social worker with a master's degree from an accredited program and two years of clinical experience under the supervision of a Qualified Mental Health Professional;

(4) a registered nurse with a graduate degree in psychiatric nursing and two years of clinical experience under the supervision of a Qualified Mental Health Professional.

d. "Non-Professional Staff Member" – an employee of the hospital, other than a Qualified Mental Health Professional, whose duties require contact with or supervision of patients.

II. Humane Psychological and Physical Environment

1. Patients have a right to privacy and dignity.

2. Patients have a right to the least restrictive conditions necessary to achieve the purposes of commitment.

3. No person shall be deemed incompetent to manage his affairs, to contract, to hold professional or occupational or vehicle operator's licenses, to marry and obtain a divorce, to register and vote, or to make a will *solely* by reason of his admission or commitment to the hospital.

4. Patients shall have the same rights to visitation and telephone communications as patients at other public hospitals, except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued. Patients shall have an unrestricted right to visitation with attorneys and with private physicians and other health professionals.

5. Patients shall have an unrestricted right to send sealed mail. Patients shall have an unrestricted right to receive sealed mail from their attorneys, private physicians, and other mental health professionals, from courts, and government officials. Patients shall have a right to receive sealed mail from others, except to the extent that the Qualified Mental Health Professional responsible for formulation of a particular patient's treatment plan writes an order imposing special restrictions on receipt of sealed

mail. The written order must be renewed after each periodic review of the treatment plan if any restrictions are to be continued.

6. Patients have a right to be free from unnecessary or excessive medication. No medication shall be administered unless at the written order of a physician. The superintendent of the hospital and the attending physician shall be responsible for all medication given or administered to a patient. The use of medication shall not exceed standards of use that are advocated by the United States Food and Drug Administration. Notation of each individual's medication shall be kept in his medical records. At least weekly the attending physician shall review the drug regimen of each patient under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days. Medication shall not be used as punishment, for the convenience of staff, as a substitute for program, or in quantities that interfere with the patient's treatment program.

7. Patients have a right to be free from physical restraint and isolation. Except for emergency situations, in which it is likely that patients could harm themselves or others and in which less restrictive means of restraint are not feasible, patients may be physically restrained or placed in isolation only on a Qualified Mental Health Professional's written order which explains the rationale for such action. The written order may be entered only after the Qualified Mental Health Professional has personally seen the patient concerned and evaluated whatever episode or situation is said to call for restraint or isolation. Emergency use of restraints or isolation shall be for no more than one hour, by which time a Qualified

Mental Health Professional shall have been consulted and shall have entered an appropriate order in writing. Such written order shall be effective for no more than 24 hours and must be renewed if restraint and isolation are to be continued. While in restraint or isolation the patient must be seen by qualified ward personnel who will chart the patient's physical condition (if it is compromised) and psychiatric condition every hour. The patient must have bathroom privileges every hour and must be bathed every 12 hours.

8. Patients shall have a right not to be subjected to experimental research without the express and informed consent of the patient, if the patient is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

9. Patients have a right not to be subjected to treatment procedures such as lobotomy, electro-convulsive treatment, adversive reinforcement conditioning or other unusual or hazardous treatment procedures without their express and informed consent after consultation with counsel or interested party of the patient's choice.

10. Patients have a right to receive prompt and adequate medical treatment for any physical ailments.

11. Patients have a right to wear their own clothes and to keep and use their own personal possessions except insofar as such clothes or personal possessions may be determined by a Qualified Mental Health Professional to be dangerous or otherwise inappropriate to the treatment regimen.

12. The hospital has an obligation to supply an adequate allowance of clothing to any patients who do not have suitable clothing of their own. Patients shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the patient's throughout his stay in the hospital.

13. The hospital shall make provision for the laundering of patient clothing.

14. Patients have a right to regular physical exercise several times a week. Moreover, it shall be the duty of the hospital to provide facilities and equipment for such exercise.

15. Patients have a right to be outdoors at regular and frequent intervals, in the absence of medical considerations.

16. The right to religious worship shall be accorded to each patient who desires such opportunities. Provisions for such worship shall be made available to all patients on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

17. The institution shall provide, with adequate supervision, suitable opportunities for the patient's interaction with members of the opposite sex.

18. The following rules shall govern patient labor:

A. Hospital Maintenance No patient shall be required to perform labor which involves the operation and maintenance of the hospital or for which the hospital is under contract with an outside organization. Privileges or release from the hospital shall not be conditioned upon the performance of labor covered by this provision. Patients may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

B. Therapeutic Tasks and Therapeutic Labor

(1) Patients may be required to perform therapeutic tasks which do not involve the operation and maintenance of the hospital, provided the specific task or any change in assignment is:

a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and

b. Supervised by a staff member to oversee the therapeutic aspects of the activity.

(2) Patients may voluntarily engage in therapeutic labor for which the hospital would otherwise have to pay an employee, provided the specific labor or any change in labor assignment is:

a. An integrated part of the patient's treatment plan and approved as a therapeutic activity by a Qualified Mental Health Professional responsible for supervising the patient's treatment; and

b. Supervised by a staff member to oversee the therapeutic aspects of the activity; and

c. Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. § 206 as amended, 1966.

C. *Personal Housekeeping* Patients may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

D. Payment to patients pursuant to these paragraphs shall not be applied to the costs of hospitalization.

19. Physical Facilities

A patient has a right to a humane psychological and physical environment within the hospital facilities. These facilities shall be designed to afford patients with comfort and safety, promote dignity, and ensure privacy. The facilities shall be designed to make a positive contribution to the efficient attainment of the treatment goals of the hospital.

A. Resident Unit

The number of patients in a multi-patient room shall not exceed six persons. There shall be allocated a minimum of 80 square feet of floor space per patient in a multi-patient room. Screens or curtains shall be provided to ensure privacy within the resident unit. Single rooms

shall have a minimum of 100 square feet of floor space. Each patient will be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, a chair, and a bedside table.

B. Toilets and Lavatories

There will be one toilet provided for each eight patients and one lavatory for each six patients. A lavatory will be provided with each toilet facility. The toilets will be installed in separate stalls to ensure privacy, will be clean and free of odor, and will be equipped with appropriate safety devices for the physically handicapped.

C. Showers

There will be one tub or shower for each 15 patients. If a central bathing area is provided, each shower area will be divided by curtains to ensure privacy. Showers and tubs will be equipped with adequate safety accessories.

D. Day Room

The minimum day room area shall be 40 square feet per patient. Day rooms will be attractive and adequately furnished with reading lamps, tables, chairs, television and other recreational facilities. They will be conveniently located to patients' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story hospital. Areas used for corridor traffic cannot be counted as day room

space; nor can a chapel with fixed pews be counted as a day room area.

E. Dining Facilities

The minimum dining room area shall be ten square feet per patient. The dining room shall be separate from the kitchen and will be furnished with comfortable chairs and tables with hard, washable surfaces.

F. Linen Servicing and Handling

The hospital shall provide adequate facilities and equipment for handling clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, no less than every seven days to assure patient comfort.

G. Housekeeping

Regular housekeeping and maintenance procedures which will ensure that the hospital is maintained in a safe, clean, and attractive condition will be developed and implemented.

H. Geriatric and Other Nonambulatory Mental Patients

There must be special facilities for geriatric and other nonambulatory patients to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory patients to communicate their needs to staff.

I. Physical Plant

(1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation in accordance with the needs of the health, comfort, safety and well-being of the patients.

(2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of patients at all times and the removal of undesired heat, steam and offensive odors. Such facilities shall ensure that the temperature in the hospital shall not exceed 83?F nor fall below 68?F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for patient or resident use (110?F at the fixture) and for mechanical dishwashing and laundry use (180?F at the equipment).

(4) Adequate refuse facilities will be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.

(5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the hospital shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to hospitals.

19A. The hospital shall meet all standards established by the state for general hospitals, insofar as they are relevant to psychiatric facilities.

20. Nutritional Standards

Patients, except for the non-mobile, shall eat or be fed in dining rooms. The diet for patients will provide at a minimum the Recommended Daily Dietary Allowances as developed by the National Academy of Sciences. Menus shall be satisfying and nutritionally adequate to provide the Recommended Daily Dietary Allowances. In developing such menus, the hospital will utilize the Low Cost Food Plan of the Department of Agriculture. The hospital will not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Low Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of patients, discounted for any savings which might result from institutional procurement of such food. Provisions shall be made for special therapeutic diets and for substitutes at the request of the patient, or his guardian or next of kin, in accordance with the religious requirements of any patient's faith. Denial of a nutritionally adequate diet shall not be used as punishment.

III. Qualified Staff in Numbers Sufficient to Administer Adequate Treatment

21. Each Qualified Mental Health Professional shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their speciality elsewhere in Alabama.

22.a. All Non-Professional Staff Members who have not had prior clinical experience in a mental institution shall have a substantial orientation training.

b. Staff members on all levels shall have regularly scheduled in-service training.

23. Each Non-Professional Staff Member shall be under the direct supervision of a Qualified Mental Health Professional.

24. Staffing Ratios

The hospital shall have the following minimum numbers of treatment personnel per 250 patients. Qualified Mental Health Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Changes in staff deployment may be made with prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure will enhance the treatment of the patients.

Classification	Number of Employees
Unit Director	1
Psychiatrist (3 years' residency training in psychiatry)	2
MD (Registered physicians)	4
Nurses (RN)	12
Licensed Practical Nurses	6
Aide III	6
Aide II	15
Aide I	70
Hospital Orderly	10
Clerk Stenographer II	3
Clerk Typist II	3
Unit Administrator	1
Administrative Clerk	1
Psychologist (Ph.D.) (doctoral degree from accredited program)	1
Psychologist (M.A.)	1
Psychologist (B.S.)	2
Social Worker (MSW) (from accredited program)	2
Social Worker (B.A.)	5
Patient Activity Therapist (M.S.)	1

Patient Activity Aide	10
Mental Health Technician	10
Dental Hygienist	1
Chaplain	.5
Vocational Rehabilitation Counselor	1
Volunteer Services Worker	1
Mental Health Field Representative	1
Dietitian	1
Food Service Supervisor	1
Cook II	2
Cook I	3
Food Service Worker	15
Vehicle Driver	10
Housekeeper	10
Messenger	1
Maintenance Repairman	2

IV. Individualized Treatment Plans

25. Each patient shall have a comprehensive physical and mental examination and review of behavioral status within 48 hours after admission to the hospital.

26. Each patient shall have an individualized treatment plan. This plan shall be developed by appropriate Qualified Mental Health Professionals, including a psychiatrist, and implemented as soon as possible – in any event no later than five days after the patient's admission. Each individualized treatment plan shall contain:

a. a statement of the nature of the specific problems and specific needs of the patient;

b. a statement of the least restrictive treatment conditions necessary to achieve the purposes of commitment;

c. a description of intermediate and long-range treatment goals, with a projected timetable for their attainment;

d. a statement and rationale for the plan of treatment for achieving these intermediate and long-range goals;

e. a specification of staff responsibility and a description of proposed staff involvement with the patient in order to attain these treatment goals;

f. criteria for release to less restrictive treatment conditions, and criteria for discharge;

g. a notation of any therapeutic tasks and labor to be performed by the patient in accordance with Standard 18.

27. As part of his treatment plan, each patient shall have an individualized post-hospitalization plan. This plan shall be developed by a Qualified Mental Health Professional as soon as practicable after the patient's admission to the hospital.

28. In the interests of continuity of care, whenever possible, one Qualified Mental Health Professional (who need not have been involved with the development of the treatment plan) shall be responsible for supervising the implementation of the treatment plan, integrating the various aspects of the treatment program and recording

the patient's progress. This Qualified Mental Health Professional shall also be responsible for ensuring that the patient is released, where appropriate, into a less restrictive form of treatment.

29. The treatment plan shall be continuously reviewed by the Qualified Mental Health Professional responsible for supervising the implementation of the plan and shall be modified if necessary. Moreover, at least every 90 days, each patient shall receive a mental examination from, and his treatment plan shall be reviewed by, a Qualified Mental Health Professional other than the professional responsible for supervising the implementation of the plan.

30. In addition to treatment for mental disorders, patients confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.[1] In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the patient's treatment for mental illness with his medical treatment.

31. Complete patient records shall be kept on the ward in which the patient is placed and shall be available to anyone properly authorized in writing by the patient. These records shall include:

a. Identification data, including the patient's legal status;

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[1] Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlon.

b. A patient history, including but not limited to:

(1) family data, educational background, and employment record;

(2) prior medical history, both physical and mental, including prior hospitalization;

c. The chief complaints of the patient and the chief complaints of others regarding the patient;

d. An evaluation which notes the onset of illness, the circumstances leading to admission, attitudes, behavior, estimate of intellectual functioning, memory functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative, fashion;

e. A summary of each physical examination which describes the results of the examination;

f. A copy of the individual treatment plan and any modifications thereto;

g. A detailed summary of the findings made by the reviewing Qualified Mental Health Professional after each periodic review of the treatment plan which analyzes the successes and failures of the treatment program and directs whatever modifications are necessary;

h. A copy of the individualized post-hospitalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

i. A medication history and status, which includes the signed orders of the prescribing physician. Nurses shall indicate by signature that orders have been carried out;

j. A detailed summary of each significant contact by a Qualified Mental Health Professional with the patient;

k. A detailed summary on at least a weekly basis by a Qualified Mental Health Professional involved in the patient's treatment of the patient's progress along the treatment plan;

l. A weekly summary of the extent and nature of the patient's work activities described in Standard 18, *supra,* and the effect of such activity upon the patient's progress along the treatment plan;

m. A signed order by a Qualified Mental Health Professional for any restrictions on visitations and communication, as provided in Standards 4 and 5, *supra;*

n. A signed order by a Qualified Mental Health Professional for any physical restraints and isolation, as provided in Standard 7, *supra;*

o. A detailed summary of any extraordinary incident in the hospital involving the patient to be entered by a staff member noting that he has personal knowledge of the incident or specifying his other source of information, and initialed within 24 hours by a Qualified Mental Health Professional;

p. A summary by the superintendent of the hospital or his appointed agent of his findings after the 15-day review provided for in Standard 33 *infra.*

32. In addition to complying with all the other standards herein, a hospital shall make special provisions for the treatment of patients who are children and young

adults. These provisions shall include but are not limited to:

a. Opportunities for publicly supported education suitable to the educational needs of the patient. This program of education must, in the opinion of the attending Qualified Mental Health Professional, be compatible with the patient's mental condition and his treatment program, and otherwise be in the patient's best interest.

b. A treatment plan which considers the chronological, maturational, and developmental level of the patient;

c. Sufficient Qualified Mental Health Professionals, teachers, and staff members with specialized skills in the care and treatment of children and young adults;

d. Recreation and play opportunities in the open air where possible and appropriate residential facilities;

e. Arrangements for contact between the hospital and the family of the patient.

33. No later than 15 days after a patient is committed to the hospital, the superintendent of the hospital or his appointed, professionally qualified agent shall examine the committed patient and shall determine whether the patient continues to require hospitalization and whether a treatment plan complying with Standard 26 has been implemented. If the patient no longer requires hospitalization in accordance with the standards for commitment, or if a treatment plan has not been implemented, he must be released immediately unless he agrees to continue with treatment on a voluntary basis.

34. The Mental Health Board and its agents have an affirmative duty to provide adequate transitional treatment and care for all patients released after a period of involuntary confinement. Transitional care and treatment possibilities include, but are not limited to, psychiatric day care, treatment in the home by a visiting therapist, nursing home or extended care, out-patient treatment, and treatment in the psychiatric ward of a general hospital.

V. Miscellaneous

35. Each patient and his family, guardian, or next friend shall promptly upon the patient's admission receive written notice, in language he understands, of all the above standards for adequate treatment. In addition a copy of all the above standards shall be posted in each ward.

APPENDIX B
BRYCE HUMAN RIGHTS COMMITTEE

1.	Mr. Bert Bank-Chairman	– P. O. Box 2149, Tuscaloosa, Alabama 35401
2.	Ms. Ruth Cummings Bolden	– 1414 9th Street, Tuscaloosa, Alabama 35401
3.	Ms. Babs Klein Heilpern	– 2526 Jasmine Road, Montgomery, Alabama 36111
4.	Mr. Joseph Mallisham	– 3028 20th Street, Tuscaloosa, Alabama 35401
5.	Ms. Alberta Murphy	– 13 Hillcrest, Tuscaloosa, Alabama 35401
6.	Mr. Junior Richardson	– 17 CW, Bryce Hospital, Tuscaloosa, Alabama 35401
7.	Mr. John T. Wagnon, Jr.	– 822 Felder Avenue, Montgomery, Alabama 36106

SEARCY HUMAN RIGHTS COMMITTEE

1.	Dr. E. L. McCafferty, Jr.-Chairman	– 1653 Spring Hill Avenue, Mobile, Alabama 36604
2.	Hon. James U. Blacksher	– 304 South Monterey, Mobile, Alabama
3.	Hon. Thomas E. Gilmore	– P. O. Box 109, Eutaw, Alabama 35462
4.	Ms. Consuello J. Harper	– 3114 Caffey Drive, Montgomery, Alabama 36108
5.	Hon. Horace McCloud	– Mount Vernon, Alabama
6.	Sister Eileen McLoughlin	– 404 Government Street, Mobile, Alabama 36601
7.	Ms. Joyce Nickels	– c/o Searcy Hospital, Mount Vernon, Alabama

Ricky WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., et al., for themselves jointly and severally and for all others similarly situated, Plaintiffs,

v.

Dr. Stonewall B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, et al., Defendants,
United States of America et al., Amici Curiae.

Civ. A. No. 3195-N.

United States District Court,
M. D. Alabama, N. D.

April 13, 1972.

Attorneys' Fees Taxed June 2, 1972.

George W. Dean, Jr., Destin, Fla., Jack Drake (Drake, Knowles & Still), Tuscaloosa, Ala., Reber F. Boult, Jr., Atlanta, Ga., Morton Birnbaum, Brooklyn, N. Y., for plaintiffs.

William J. Baxley, Atty. Gen. of Alabama, J. Jerry Wood, Asst. Atty. Gen. of Alabama, Montgomery, Ala., John J. Coleman, Special Asst. Atty. Gen. of Alabama, Birmingham, Ala., for defendants.

Ira DeMent, U. S. Atty., Middle District of Alabama, Montgomery, Ala., Robert H. Johnson and David J. W. Vanderhoof, Civil Rights Division, U. S. Dept. of Justice, Washington, D. C., Cleveland Thornton, Special Asst. U.S. Atty., Middle District of Alabama, Montgomery, Ala., for United States amici curiae.

Charles R. Halpern (Center for Law & Social Policy), James F. Fitzpatrick, Stephen M. Sacks, and Jeffrey D.

Bauman (Arnold & Porter), Washington, D. C., Bruce Ennis (American Civil Liberties Union), New York City, Stanley Herr (NLADA National Law Office), Washington, D. C., Shelley Mercer (National Health and Environmental Program, School of Law, UCLA), Los Angeles, Cal., Paul Friedman (Center for Law and Social Policy), Washington, D. C., for other amici curiae.

ORDER AND DECREE

JOHNSON, Chief Judge.

This litigation originally pertained only to Alabama's mentally ill,[1] but by motion to amend granted August 12,

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[1] On March 12, 1971, in a formal opinion and decree, this Court held that patients involuntarily committed to Bryce Hospital because of mental illness were being deprived of the constitutional right, which they unquestionably possess, "to receive such individual treatment as [would] give each of them a realistic opportunity to be cured or to improve his or her mental condition." *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala.1971). On August 12, 1971, the Court granted plaintiffs' motion to add to the lawsuit patients confined at Searcy Hospital, Mount Vernon, Alabama, another institution which, although designed to treat the mentally ill, failed to do so in accordance with constitutional standards. The Court, having unavailingly afforded defendants an opportunity to promulgate and effectuate minimum standards for adequate treatment of the mentally ill, determined on December 10, 1971, that such standards had to be judicially formulated and ordered implemented. *Wyatt v. Stickney*, 334 F.Supp. 1341 (M.D.Ala.1971). To that end, the Court conducted a hearing on February 3-4, 1972, at which the parties and amici submitted proposed standards for constitutionally adequate treatment, and presented expert testimony in support of the proposals. The aspect of the case relating to the Bryce-Searcy facilities will be

1971, plaintiffs have expanded their class to include residents of Partlow State School and Hospital, a public institution located in Tuscaloosa, Alabama, designed to habilitate the mentally retarded.[2] In their amended complaint, plaintiffs have alleged that Partlow is being operated in a constitutionally impermissible fashion and that, as a result, its residents are denied the right to adequate habilitation. Relying on these allegations, plaintiffs have asked that the Court promulgate and order the implementation at Partlow of minimum medical and constitutional standards appropriate for the functioning of such an institution. Plaintiffs have asked also that the Court appoint a master and a professional advisory committee to oversee the implementation of judicially ordered

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considered by the Court in a decree separate from the present one.

[2] As expressed by amici in their briefs and substantiated by the evidence in this case, *mental retardation* refers generally to sub-average intellectual functioning which is associated with impairment in adaptive behavior. This definitional approach to mental retardation is based upon dual criteria: reduced intellectual functioning and impairment in adaptation to the requirements of social living. The evidence presented reflects scientific advances in understanding the developmental processes of the mental retardate. The historic view of mental retardation as an immutable defect of intelligence has been supplanted by the recognition that a person may be mentally retarded at one age level and not at another; that he may change status as a result of changes in the level of his intellectual functioning; or that he may move from retarded to non-retarded as a result of a training program which has increased his level of adaptive behavior to a point where his behavior is no longer of concern to society. See United States President's Panel on Mental Retardation, Report of the Task Force on Law, 1963. (Judge David L. Bazelon, Chairman.)

guidelines and appoint a human rights committee to safeguard the personal rights and dignity of the residents. Finally plaintiffs have requested the Court to grant various forms of relief intended to ameliorate the financial difficulties certain to arise in connection with the upgrading of Alabama's public mental health institutions.[3]

On February 28-29, 1972, the Court conducted a hearing on the issues formulated by the pleadings in this case. Evidence was taken on the adequacy of conditions currently existing at Partlow as well as on the standards requisite for a constitutionally acceptable minimum habilitation program. The parties and amici[4] stipulated to a broad array of these standards and proposed additional

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[3] More specifically, in a motion filed September 1, 1971, and renewed March 15, 1972, plaintiffs have asked that they be permitted to join various state officials as defendants in this case. Plaintiffs maintain that these officials, including, among others, the members of the State Legislature and the treasurer and the comptroller of Alabama, are necessary parties for the attainment of complete relief. Among the relief plaintiffs seek in connection with the state officials is an injunction against the expenditure of state funds for nonessential functions of the state until enough money is available to provide adequately for the financial needs of the Alabama Mental Health Board. In addition, plaintiffs have asked the Court to order the sale of a portion of defendant Mental Health Board's land holdings and other assets and to enjoin the Board from the construction of any physical facilities, including any planned for regional centers.

[4] The amici in this case, including the United States of America, the American Orthopsychiatric Association, the American Psychological Association, the American Civil Liberties Union, and the American Association on Mental Deficiency, have performed invaluable service for which this Court is indeed appreciative.

ones for the Court's evaluation. The case now is submitted upon the pleadings, the evidence, the stipulations, and the proposed standards and briefs of the parties.

Initially, this Court has considered plaintiffs' position, not actively contested by defendants, that people involuntarily committed[5] through noncriminal procedures to institutions for the mentally retarded have a constitutional right to receive such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society. That this position is in accord with the applicable legal principles is clear beyond cavil. In an analogous situation involving the mentally ill at Bryce Hospital this Court said:

> "Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed 'into a penitentiary where one could be held indefinitely for no convicted offense.' *Ragsdale v. Overholser,* [108 U.S.App.D.C. 308] 281 F.2d 943, 950 (1960). The

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[5] The Court will deal in this decree only with residents involuntarily committed to Partlow because no evidence has been adduced tending to demonstrate that any resident is voluntarily confined in that institution. The Court will presume, therefore, that every resident of Partlow is entitled to constitutionally minimum habilitation. The burden falls squarely upon the institution to prove that a particular resident has not been involuntarily committed, and only if defendants satisfy this difficult burden of proof will the Court be confronted with whether the voluntarily committed resident has a right to habilitation.

> purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions such as Bryce." *Wyatt v. Stickney,* 325 F.Supp. at 784.

In the context of the right to appropriate care for people civilly confined to public mental institutions, no viable distinction can be made between the mentally ill and the mentally retarded. Because the only constitutional justification for civilly committing a mental retardate, therefore, is habilitation, it follows ineluctably that once committed such a person is possessed of an inviolable constitutional right to habilitation.[6]

Having recognized the existence of this right, the Court now must determine whether prevailing conditions at Partlow conform to minimum standards constitutionally required for a mental retardation institution. The Court's conclusion, compelled by the evidence, is unmistakably clear. Put simply, conditions at Partlow are

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[6] It is interesting to note that the Court's decision with regard to the right of the mentally retarded to habilitation is supported not only by applicable legal authority, but also by a resolution adopted on December 27, 1971, by the General Assembly of the United Nations. That resolution, entitled "Declaration on the Rights of the Mentally Retarded", reads in pertinent part:

> " . . . The mentally retarded person has a right to proper medical care and physical therapy and to such education, training, rehabilitation and guidance as will enable him to develop his ability and maximum potential."

grossly substandard. Testimony presented by plaintiffs and amici has depicted hazardous and deplorable inadequacies in the institution's operation.[7] Commendably,

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[7] The most comprehensive testimony on the conditions currently prevailing at Partlow was elicited from Dr. Philip Roos, the Executive Director for the National Association for Retarded Children. Dr. Roos inspected Partlow over a two-day period and testified as to his subjective evaluation of the institution. In concluding his testimony, Dr. Roos summarized as follows:

> "... I feel that the institution and its programs as now conceived are incapable of providing habilitation of the residents. Incarceration, certainly for most of the residents, would I feel have adverse consequences; would tend to develop behaviors which would interfere with successful community functioning. I would anticipate to find stagnation or deterioration in physical, intellectual, and social spheres. The conditions at Partlow today are generally dehumanizing, fostering deviancy, generating self-fulfilling prophecy of parasitism and helplessness. The conditions I would say are hazardous to psychological integrity, to health, and in some cases even to life. The administration, the physical plants, the programs, and the institution's articulation with the community and with the consumers reflect destructive models of mental retardation. They hark back to decades ago when the retarded were misperceived as being sick, as being threats to society, or as being subhuman organisms. The new concepts in the field of mental retardation are unfortunately not reflected in Partlow as we see it today-concepts such as normalization, developmental model in orientation toward mental retardation, the thrust of consumer involvement, the trend toward community orientation and decentralization of services; none of these are clearly in evidence in the facility today."

defendants have offered no rebuttal.[8] At the close of the testimony, the Court, having been impressed by the urgency of the situation, issued an interim emergency order "to protect the lives and well-being of the residents of Partlow." In that order, the Court found that:

> "The evidence . . . has vividly and undisputedly portrayed Partlow State School and Hospital as a warehousing institution which, because of its atmosphere of psychological and physical deprivation, is wholly incapable of furnishing [habilitation] to the mentally retarded and is conducive only to the deterioration and the debilitation of the residents. The evidence has reflected further that safety and sanitary conditions at Partlow are substandard to the point of endangering the health and lives of those residing there, that the wards are grossly understaffed, rendering even simple custodial care impossible, and that overcrowding remains a dangerous problem often leading to serious accidents, some of which have resulted in deaths of residents." *Wyatt v. Stickney*, March 2, 1972. (Unreported Interim Emergency Order.)

Based upon these findings, the Court has concluded that plaintiffs have been denied their right to habilitation

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[8] Indeed, on February 22, 1972, defendants filed with the Court a statement of position providing in relevant part that:

> "Assuming that such a federal constitutional obligation exists . . . , defendants will not contest the factual accuracy of an ultimate finding . . . that defendants have not met the constitutional obligation to provide adequate care at [Partlow], . . . "
>
> At the hearing, defendants adopted the testimony of Dr. Roos in its entirety.

and that, pursuant to plaintiffs' request, minimum standards for constitutional care and training must be effectuated at Partlow. Consequently, having determined from a careful study of the evidence that the standards set out in Appendix A to this decree are medical and constitutional minimums, this Court will order their implementation.[9] In so ordering, the Court emphasizes that these standards are, indeed, minimums only peripherally approaching the ideal to which defendants should aspire. It is hoped that the revelations of this case will furnish impetus to defendants to provide physical facilities and habilitation programs at Partlow substantially exceeding medical and constitutional minimums.

For the present, however, defendants must realize that the prompt institution of minimum standards to ensure the provision of essential care and training for Alabama's mental retardates is mandatory and that no default can be justified by a want of operating funds. In this regard, the principles applicable to the mentally ill apply with equal force to the mentally retarded. *See Wyatt v. Stickney*, 325 F.Supp. at 784-785.

In addition to requesting that minimum standards be implemented, plaintiffs have asked that defendants be

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[9] In addition to the standards detailed in this order, it is appropriate that defendants comply also with the conditions, applicable to mental health institutions, necessary to qualify Partlow for participation in the various programs, such as Medicare and Medicaid, funded by the United States Government. Because many of these conditions of participation have not yet been finally drafted and published, however, this Court will not at this time order that specific Government standards be implemented.

directed to establish a standing human rights committee to guarantee that residents are afforded constitutional and humane habilitation. The evidence reflects that such a committee is needed at Partlow, and this Court will order its initiation. This committee shall have review of all research proposals and all habilitation programs to ensure that the dignity and human rights of residents are preserved. The committee also shall advise and assist residents who allege that their legal rights have been infringed or that the Mental Health Board has failed to comply with judicially ordered guidelines. At reasonable times the committee may inspect the records of the institution and interview residents and staff. At its discretion the committee may consult appropriate, independent specialists who shall be compensated by the defendant Board.[10] The Court will appoint seven members to comprise Partlow's human rights committee, the names and addresses of whom are set forth in Appendix B to this decree. Those who serve on the committee shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health.

Plaintiffs, as well as amici, also have advocated the appointment of a federal master and a professional advisory committee to oversee the implementation of minimum constitutional standards. These parties maintain

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[10] The recitation of the licenses of this committee, and similarly, of the committees to be inaugurated at the Bryce and Searcy facilities, is not intended to be inclusive. The human rights committee of each mental health institution shall be authorized, within the limits of reasonableness, to pursue whatever action is necessary to accomplish its function.

that conditions at Partlow largely are the product of shameful neglect by the state officials charged with responsibility for that institution. Consequently, plaintiffs and amici insist, these state officials have proved themselves incapable of instituting a constitutional habilitation program. Although this Court acknowledges the intolerable conditions at Partlow and recognizes defendants' past nonfeasances, it, nevertheless, reserves ruling on the appointment of a master and a professional advisory committee.[11] Federal courts are reluctant to assume control of any organization, but especially one operated by a state. This Court, always having shared that reluctance, has adhered to a policy of allowing state officials one final opportunity to perform the duties imposed upon them by law. *See e. g., Sims v. Amos*, 336 F.Supp. 924 (M.D.Ala.1972); *Nixon v. Wallace*, C.A. No. 3479-N, M.D.Ala., January 22, 1972. Additionally, since the entry of the interim emergency order of March 2, 1972, defendants have worked diligently to upgrade conditions at Partlow in conformity with court-established deadlines.

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[11] The Court's decision to reserve ruling on the appointment of a master causes it to reserve ruling also on the appointment of a professional advisory committee to aid the master. Nevertheless, the Court notes that the professional mental health community in the United States has responded with enthusiasm to the proposed initiation of such a committee to assist in the upgrading of Alabama's mental retardation services. Consequently, this Court strongly recommends to defendants that they develop a professional advisory committee comprised of amenable professionals from throughout the country who are able to provide the expertise the evidence reflects is important to the successful implementation of this order.

These factors, combined with defendants' expressed intent that the present order will be implemented forthwith and in good faith, cause the Court to withhold its decision on the appointments. Nevertheless, this Court notes, and the evidence demonstrates convincingly, that the operation of Partlow suffers from a virtual absence of administrative and managerial organization. This long-enduring organizational deficiency has been intensified by the lack of dynamic, permanent leadership. Regrettably, the problem has remained unresolved over the span of this litigation and, indeed, has been compounded by the appointment of acting and interim superintendents. The massive program of reform and reorganization to be launched at Partlow requires the guidance of a professionally qualified and experienced administrator. Consequently, this Court will order that defendants employ such an individual on a permanent basis. Should defendants fail to do so, or otherwise fail to comply timely with the provisions of this decree, the Court will be obligated to appoint a master.

The Court also reserves ruling upon plaintiffs' motion that defendant Mental Health Board be directed to sell or encumber portions of its extensive land holdings. Similarly, this Court reserves ruling on plaintiffs' motion seeking an injunction against the expenditure of state funds for nonessential functions of the state, and on other aspects of plaintiffs' requested relief designed to ameliorate the financial problems incident to the effectuation of minimum medical and constitutional standards. The Court reserves these rulings despite the fact that the primitive conditions, as well as the atmosphere of futility and despair which envelops both staff and residents at

Partlow, can be attributed largely to dire shortages of operating funds. By withholding its decisions, the Court continues to observe its longstanding policy of deferring to state organizations and officials charged by law with specified responsibilities. The responsibility for appropriate funding ultimately must fall, of course, upon the State Legislature and, only to a lesser degree, upon the defendant Mental Health Board. Unfortunately, never, since the founding of Partlow in 1923, has the Legislature adequately provided for that institution.[12] The result of almost fifty years of legislative neglect has been catastrophic; atrocities occur daily.[13] Although, in fairness, the present State Legislature can be faulted relatively little for the crisis situation at Partlow, only that body can rectify the gross omissions of past Legislatures. To shrink from its constitutional obligation at this critical juncture

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[12] By defendants' admission, Partlow State School and Hospital always has been a "step-child" of the state – never having received the public support it so desperately required. Not until the short term in office of Governor Lurleen Wallace was any emphasis placed upon securing adequate care for Alabama's mentally retarded. Beginning with Mrs. Wallace's tenure in 1966, the budget for mental health has increased but remains woefully short of the minimum required for constitutional care.

[13] A few of the atrocious incidents cited at the hearing in this case include the following: (a) a resident was scalded to death by hydrant water; (b) a resident was restrained in a strait jacket for nine years in order to prevent hand and finger sucking; (c) a resident was inappropriately confined in seclusion for a period of years, and (d) a resident died from the insertion by another resident of a running water hose into his rectum. Each of these incidents could have been avoided had adequate staff and facilities been available.

would be to sanction the inhumane conditions which plague the mentally retarded of Alabama. The gravity and immediacy of the situation cannot be overemphasized. At stake is the very preservation of human life and dignity. Consequently, a prompt response from the State Legislature, as well as from the Mental Health Board and other responsible state officials, is imperative.

In the event, though, that the Legislature fails to satisfy its well-defined constitutional obligation and the Mental Health Board, because of lack of funding or any other legally insufficient reason, fails to implement fully the standards herein ordered, it will be necessary for the Court to take affirmative steps, including appointing a master, to ensure that proper funding is realized[14] and that adequate habilitation is available for the mentally retarded of Alabama.

Finally, the Court has determined that this case requires the awarding of a reasonable attorneys' fee to plaintiffs' counsel. The basis for the award and the amount thereof will be considered and treated in a separate order. The fee will be charged against the defendants as a part of the court costs in this case.

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[14] The Court realizes that the Legislature is not due back in regular session until May, 1973. Nevertheless, special sessions of the Legislature are frequent occurrences in Alabama, and there has never been a time when such a session was more urgently required. If the Legislature does not act promptly to appropriate the necessary funding for mental health, the Court will be compelled to grant plaintiffs' motion to add various state officials and agencies as additional parties to this litigation and to utilize other avenues of fund raising.

To assist the Court in its determination of how to proceed henceforth, defendants will be directed to prepare and file a report within six months from the date of this decree detailing the implementation of each standard herein ordered. This report shall be comprehensive and shall include a statement of the progress made on each standard not yet completely implemented, specifying the reasons for incomplete performance. The report shall include also a statement of the financing secured since the issuance of this decree and of defendants' plans for procuring whatever additional financing might be required. Upon the basis of this report and other information available, the Court will evaluate defendants' work and, in due course, determine the appropriateness of appointing a master and of granting other requested relief.

Accordingly, it is the order, judgment, and decree of this Court:

1. That defendants be and they are hereby enjoined from failing to implement fully and with dispatch each of the standards set forth in Appendix A attached hereto and incorporated as a part of this decree;

2. That a human rights committee for Partlow State School and Hospital be and is hereby designated and appointed. The members thereof are listed in Appendix B attached hereto and incorporated herein. This committee shall have the purposes, functions, and spheres of operation previously set forth in this order. The members of the committee shall be paid on a per diem basis and be reimbursed for travel expenses at the same rate as members of the Alabama Board of Mental Health;

3. That defendants, within 60 days from this date, employ a professionally qualified and experienced administrator to serve Partlow State School and Hospital on a permanent basis;

4. That defendants, within six months from this date, prepare and file with this Court a report reflecting in detail the progress on the implementation of this order. This report shall be comprehensive and precise and shall explain the reasons for incomplete performance in the event the defendants have not met a standard in its entirety. The report also shall include a financial statement and an up-to-date timetable for full compliance;

5. That the court costs incurred in this proceeding, including a reasonable attorneys' fee for plaintiffs' lawyers be and they are hereby taxed against the defendants;

6. That jurisdiction of this cause be and the same is hereby specifically retained.

It is further ordered that a ruling on plaintiffs' motion for further relief, including the appointment of a master, filed March 15, 1972, be and the same is hereby reserved.

APPENDIX A

MINIMUM CONSTITUTIONAL STANDARDS FOR ADEQUATE HABILITATION OF THE MENTALLY RETARDED

I. Definitions

The terms used herein below are defined as follows:

a. "Institution" – Partlow State School and Hospital.

b. "Residents" – All persons who are now confined and all persons who may in the future be confined at Partlow State School and Hospital.

c. "Qualified Mental Retardation Professional" –

(1) a psychologist with a doctoral or master's degree from an accredited program and with specialized training or one year's experience in treating the mentally retarded;

(2) a physician licensed to practice in the State of Alabama, with specialized training or one's [sic] year's experience in treating the mentally retarded;

(3) an educator with a master's degree in special education from an accredited program;

(4) a social worker with a master's degree from an accredited program and with specialized training or one year's experience in working with the mentally retarded;

(5) a physical, vocational or occupational therapist licensed to practice in the State of Alabama who is a graduate of an accredited program in physical, vocational or occupational therapy, with specialized training or one year's experience in treating the mentally retarded;

(6) a registered nurse with specialized training or one year of experience treating the mentally retarded under the supervision of a Qualified Mental Retardation Professional.

d. "Resident Care Worker" – an employee of the institution, other than a Qualified Mental Retardation Professional, whose duties require regular contact with or supervision of residents.

e. "Habilitation" – the process by which the staff of the institution assists the resident to acquire and maintain those life skills which enable him to cope more effectively with the demands of his own person and of his environment and to raise the level of his physical, mental, and social efficiency. Habilitation includes but is not limited to programs of formal, structured education and treatment.

f. "Education" – the process of formal training and instruction to facilitate the intellectual and emotional development of residents.

g. "Treatment" – the prevention, amelioration and/or cure of a resident's physical disabilities or illnesses.

h. "Guardian" – a general guardian of a resident, unless the general guardian is missing, indifferent to the welfare of the resident or has an interest adverse to the resident. In such a case, *guardian* shall be defined as an individual appointed by an appropriate court on the motion of the superintendent, such guardian not to be in the control or in the employ of the Alabama Board of Mental Health.

i. "Express and Informed Consent" – the uncoerced decision of a resident who has comprehension and can signify assent or dissent.

II. Adequate Habilitation of Residents

1. Residents shall have a right to habilitation, including medical treatment, education and care, suited to their needs, regardless of age, degree of retardation or handicapping condition.

2. Each resident has a right to a habilitation program which will maximize his human abilities and enhance his ability to cope with his environment. The institution shall recognize that each resident, regardless of ability or status, is entitled to develop and realize his fullest potential. The institution shall implement the principle of normalization so that each resident may live as normally as possible.

3. a. No person shall be admitted to the institution unless a prior determination shall have been made[1] that residence in the institution is the least restrictive habilitation setting feasible for that person.

b. No mentally retarded person shall be admitted to the institution if services and programs in the community can afford adequate habilitation to such person.

c. Residents shall have a right to the least restrictive conditions necessary to achieve the purposes of habilitation. To this end, the institution shall make every attempt to move residents

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[1] See Standard 7, *infra*.

from (1) more to less structured living; (2) larger to smaller facilities; (3) larger to smaller living units; (4) group to individual residence; (5) segregated from the community to integrated into the community living; (6) dependent to independent living.

4. No borderline or mildly mentally retarded person shall be a resident of the institution. For purposes of this standard, a borderline retarded person is defined as an individual who is functioning between one and two standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on measures of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale. A mildly retarded person is defined as an individual who is functioning between two and three standard deviations below the mean on a standardized intelligence test such as the Stanford Binet Scale and on a measure of adaptive behavior such as the American Association on Mental Deficiency Adaptive Behavior Scale.

5. Residents shall have a right to receive suitable educational services regardless of chronological age, degree of retardation or accompanying disabilities or handicaps.

a. The institution shall formulate a written statement of educational objectives that is consistent with the institution's mission as set forth in Standard 2, *supra*, and the other standards proposed herein.

b. School-age residents shall be provided a full and suitable educational program. Such educational program shall meet the following minimum standards:

	Severe/ Profound	Mild[2]	Moderate
(1)	Class Size	12	9
	6		
(2)	Length of school year	9-10	9-10
	11-12 (in months)		
(3)	Minimum length of	6	6
	6 school day (in hours)		

6. Residents shall have a right to receive prompt and adequate medical treatment for any physical ailments and for the prevention of any illness or disability. Such medical treatment shall meet standards of medical practice in the community.

III. Individualized Habilitation Plans

7. Prior to his admission to the institution, each resident shall have a comprehensive social, psychological, educational, and medical diagnosis and evaluation by appropriate specialists to determine if admission is appropriate.

a. Unless such preadmission evaluation has been conducted within three months prior to the admission, each resident shall have a new evaluation at the institution to determine if admission is appropriate.

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[2] As is reflected in Standard 4, supra, it is contemplated that no mildly retardedd [sic] persons be residents of the institution. However, until those mildly retardedd [sic] who are presently residents are removed to more suitable locations and/or facilities, some provision must be made for their educational program.

b. When undertaken at the institution, preadmission diagnosis and evaluation shall be completed within five days.

8. Within 14 days of his admission to the institution, each resident shall have an evaluation by appropriate specialists for programming purposes.

9. Each resident shall have an individualized habilitation plan formulated by the institution. This plan shall be developed by appropriate Qualified Mental Retardation Professionals and implemented as soon as possible but no later than 14 days after the resident's admission to the institution. An interim program of habilitation, based on the preadmission evaluation conducted pursuant to Standard 7, *supra*, shall commence promptly upon the resident's admission. Each individualized habilitation plan shall contain:

a. a statement of the nature of the specific limitations and specific needs of the resident;

b. a description of intermediate and long-range habilitation goals with a projected timetable for their attainment;

c. a statement of, and an explanation for, the plan of habilitation for achieving these intermediate and long-range goals;

d. a statement of the least restrictive setting for habilitation necessary to achieve the habilitation goals of the resident;

e. a specification of the professionals and other staff members who are responsible for the particular resident's attaining these habilitation goals;

f. criteria for release to less restrictive settings for habilitation, including criteria for discharge and a projected date for discharge.

10. As part of his habilitation plan, each resident shall have an individualized post-institutionalization plan. This plan shall be developed by a Qualified Mental Retardation Professional who shall begin preparation of such plan prior to the resident's admission to the institution and shall complete such plan as soon as practicable. The guardian or next of kin of the resident and the resident, if able to give informed consent, shall be consulted in the development of such plan and shall be informed of the content of such plan.

11. In the interests of continuity of care, one Qualified Mental Retardation Professional shall be responsible for supervising the implementation of the habilitation plan, integrating the various aspects of the habilitation program, and recording the resident's progress as measured by objective indicators. This Qualified Mental Retardation Professional shall also be responsible for ensuring that the resident is released when appropriate to a less restrictive habilitation setting.

12. The habilitation plan shall be continuously reviewed by the Qualified Mental Retardation Professional responsible for supervising the implementation of the plan and shall be modified if necessary. In addition, six months after admission and at least annually thereafter, each resident shall receive a comprehensive psychological, social, educational and medical diagnosis and evaluation, and his habilitation plan shall be reviewed by an interdisciplinary team of no less than two Qualified Mental Retardation Professionals and such resident care

workers as are directly involved in his habilitation and care.

13. In addition to habilitation for mental disorders, people confined at mental health institutions also are entitled to and shall receive appropriate treatment for physical illnesses such as tuberculosis.[3] In providing medical care, the State Board of Mental Health shall take advantage of whatever community-based facilities are appropriate and available and shall coordinate the resident's habilitation for mental retardation with his medical treatment.

14. Complete records for each resident shall be maintained and shall be readily available to Qualified Mental Retardation Professionals and to the resident care workers who are directly involved with the particular resident. All information contained in a resident's records shall be considered privileged and confidential. The guardian, next of kin, and any person properly authorized in writing by the resident, if such resident is capable of giving informed consent, or by his guardian or next of kin, shall be permitted access to the resident's records. These records shall include:

a. Identification data, including the resident's legal status;

b. The resident's history, including but not limited to:

(1) family data, educational background, and employment record;

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[3] Approximately 50 patients at Bryce-Searcy are tubercular as also are approximately four residents at Partlow.

(2) prior medical history, both physical and mental, including prior institutionalization;

c. The resident's grievances if any;

d. An inventory of the resident's life skills;

e. A record of each physical examination which describes the results of the examination;

f. A copy of the individual habilitation plan and any modifications thereto and an appropriate summary which will guide and assist the resident care workers in implementing the resident's program;

g. The findings made in periodic reviews of the habilitation plan (see Standard 12, *supra*), which findings shall include an analysis of the successes and failures of the habilitation program and shall direct whatever modifications are necessary;

h. A copy of the post-institutionalization plan and any modifications thereto, and a summary of the steps that have been taken to implement that plan;

i. A medication history and status, pursuant to Standard 22, *infra;*

j. A summary of each significant contact by a Qualified Mental Retardation Professional with the resident;

k. A summary of the resident's response to his program, prepared by a Qualified Mental Retardation Professional involved in the resident's habilitation and recorded at least monthly. Such response, wherever possible, shall be scientifically documented.

l. A monthly summary of the extent and nature of the resident's work activities described in the Standard 33(b), *infra* and the effect of such activity upon the resident's progress along the habilitation plan;

m. A signed order by a Qualified Mental Retardation Professional for any physical restraints, as provided in Standard 26(a) (1), *infra;*

n. A description of any extraordinary incident or accident in the institution involving the resident, to be entered by a staff member noting personal knowledge of the incident or accident or other source of information, including any reports of investigations of resident mistreatment, as required by Standard 28, *infra;*

o. A summary of family visits and contacts;

p. A summary of attendance and leaves from the institution;

q. A record of any seizures, illnesses, treatments thereof, and immunizations.

IV. Humane Physical and Psychological Environment

15. Residents shall have a right to dignity, privacy and humane care.

16. Residents shall lose none of the rights enjoyed by citizens of Alabama and of the United States solely by reason of their admission or commitment to the institution, except as expressly determined by an appropriate court.

17. No person shall be presumed mentally incompetent solely by reason of his admission or commitment to the institution.

18. The opportunity for religious worship shall be accorded to each resident who desires such worship. Provisions for religious worship shall be made available to all residents on a nondiscriminatory basis. No individual shall be coerced into engaging in any religious activities.

19. Residents shall have the same rights to telephone communication as patients at Alabama public hospitals, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued. Residents shall have an unrestricted right to visitation, except to the extent that a Qualified Mental Retardation Professional responsible for formulation of a particular resident's habilitation plan (see Standard 9, *supra*) writes an order imposing special restrictions and explains the reasons for any such restrictions. The written order must be renewed semiannually if any restrictions are to be continued.

20. Residents shall be entitled to send and receive sealed mail. Moreover, it shall be the duty of the institution to facilitate the exercise of this right by furnishing the necessary materials and assistance.

21. The institution shall provide, under appropriate supervision, suitable opportunities for the resident's

interaction with members of the opposite sex, except where a Qualified Mental Retardation Professional responsible for the formulation of a particular resident's habilitation plan writes an order to the contrary and explains the reasons therefor.

22. Medication:

a. No medication shall be administered unless at the written order of a physician.

b. Notation of each individual's medication shall be kept in his medical records (Standard 14(i) *supra*). At least weekly the attending physician shall review the drug regimen of each resident under his care. All prescriptions shall be written with a termination date, which shall not exceed 30 days.

c. Residents shall have a right to be free from unnecessary or excessive medication. The resident's records shall state the effects of psychoactive medication on the resident. When dosages of such are changed or other psychoactive medications are prescribed, a notation shall be made in the resident's record concerning the effect of the new medication or new dosages and the behavior changes, if any, which occur.

d. Medication shall not be used as punishment, for the convenience of staff, as a substitute for a habilitation program, or in quantities that interfere with the resident's habilitation program.

e. Pharmacy services at the institution shall be directed by a professionally competent pharmacist

licensed to practice in the State of Alabama. Such pharmacist shall be a graduate of a school of pharmacy accredited by the American Council on Pharmaceutical Education. Appropriate officials of the institution, at their option, may hire such a pharmacist or pharmacists fulltime or, in lieu thereof, contract with outside pharmacists.

f. Whether employed fulltime or on a contract basis, the pharmacist shall perform duties which include but are not limited to the following:

(1) Receiving the original, or direct copy, of the physician's drug treatment order;

(2) Reviewing the drug regimen, and any changes, for potentially adverse reactions, allergies, interactions, contraindications, rationality, and laboratory test modifications and advising the physician of any recommended changes, with reasons and with an alternate drug regimen;

(3) Maintaining for each resident an individual record of all medications (prescription and nonprescription) dispensed, including quantities and frequency of refills;

(4) Participating, as appropriate, in the continuing interdisciplinary evaluation of individual residents for the purposes of initiation, monitoring, and follow-up of individualized habilitation programs.

g. Only appropriately trained staff shall be allowed to administer drugs.

23. Seclusion, defined as the placement of a resident alone in a locked room, shall not be employed. Legitimate "time out" procedures may be utilized under close and

direct professional supervision as a technique in behavior-shaping programs.

24. Behavior modification programs involving the use of noxious or aversive stimuli shall be reviewed and approved by the institution's Human Rights Committee and shall be conducted only with the express and informed consent of the affected resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such behavior modification programs shall be conducted only under the supervision of and in the presence of a Qualified Mental Retardation Professional who has had proper training in such techniques.

25. Electric shock devices shall be considered a research technique for the purpose of these standards. Such devices shall only be used in extraordinary circumstances to prevent self-mutilation leading to repeated and possibly permanent physical damage to the resident and only after alternative techniques have failed. The use of such devices shall be subject to the conditions prescribed in Standard 24, *supra*, and Standard 29, *infra*, and shall be used only under the direct and specific order of the superintendent.

26. Physical restraint shall be employed only when absolutely necessary to protect the resident from injury to himself or to prevent injury to others. Restraint shall not be employed as punishment, for the convenience of staff, or as a substitute for a habilitation program. Restraint shall be applied only if alternative techniques have failed

and only if such restraint imposes the least possible restriction consistent with its purpose.

a. Only Qualified Mental Retardation Professionals may authorize the use of restraints.

(1) Orders for restraints by the Qualified Mental Retardation Professionals shall be in writing and shall not be in force for longer than 12 hours.

(2) A resident placed in restraint shall be checked at least every 30 minutes by staff trained in the use of restraints, and a record of such checks shall be kept.

(3) Mechanical restraints shall be designed and used so as not to cause physical injury to the resident and so as to cause the least possible discomfort.

(4) Opportunity for motion and exercise shall be provided for a period of not less than ten minutes during each two hours in which restraint is employed.

(5) Daily reports shall be made to the superintendent by those Qualified Mental Retardation Professionals ordering the use of restraints, summarizing all such uses of restraint, the types used, the duration, and the reasons therefor.

b. The institution shall cause a written statement of this policy to be posted in each living unit and circulated to all staff members.

27. Corporal punishment shall not be permitted.

28. The institution shall prohibit mistreatment, neglect or abuse in any form of any resident.

a. Alleged violations shall be reported immediately to the superintendent and there shall be a written record that:

(1) Each alleged violation has been thoroughly investigated and findings stated;

(2) The results of such investigation are reported to the superintendent and to the commissioner within 24 hours of the report of the incident. Such reports shall also be made to the institution's Human Rights Committee monthly and to the Alabama Board of Mental Health at its next scheduled public meeting.

b. The institution shall cause a written statement of this policy to be posted in each cottage and building and circulated to all staff members.

29. Residents shall have a right not to be subjected to experimental research without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and with legal counsel. Such proposed research shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought. Prior to such approval the institution's Human Rights Committee shall determine that such research complies with the principles of the Statement on the Use of Human Subjects for Research of the American Association on Mental Deficiency and with the principles for research involving human subjects required by the United States Department of Health, Education and Welfare for projects supported by that agency.

30. Residents shall have a right not to be subjected to any unusual or hazardous treatment procedures without the express and informed consent of the resident, if the resident is able to give such consent, and of his guardian or next of kin, after opportunities for consultation with independent specialists and legal counsel. Such proposed procedures shall first have been reviewed and approved by the institution's Human Rights Committee before such consent shall be sought.

31. Residents shall have a right to regular physical exercise several times a week. It shall be the duty of the institution to provide both indoor and outdoor facilities and equipment for such exercise.

32. Residents shall have a right to be outdoors daily in the absence of contrary medical considerations.

33. The following rules shall govern resident labor:

a. Institution Maintenance

(1) No resident shall be required to perform labor which involves the operation and maintenance of the institution or for which the institution is under contract with an outside organization. Privileges or release from the institution shall not be conditioned upon the performance of labor covered by this provision. Residents may voluntarily engage in such labor if the labor is compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

(2) No resident shall be involved in the care (feeding, clothing, bathing), training, or supervision of other residents unless he:

(a) has volunteered;

(b) has been specifically trained in the necessary skills;

(c) has the humane judgment required for such activities;

(d) is adequately supervised; and

(e) is reimbursed in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

b. Training Tasks and Labor

(1) Residents may be required to perform vocational training tasks which do not involve the operation and maintenance of the institution, subject to a presumption that an assignment of longer than three months to any task is not a training task, provided the specific task or any change in task assignment is:

(a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;

(b) Supervised by a staff member to oversee the habilitation aspects of the activity.

(2) Residents may voluntarily engage in habilitative labor at non-program hours for which the institution would otherwise have to pay an employee, provided the specific labor or any change in labor is:

(a) An integrated part of the resident's habilitation plan and approved as a habilitation activity by a Qualified Mental Retardation Professional responsible for supervising the resident's habilitation;

(b) Supervised by a staff member to oversee the habilitation aspects of the activity; and

(c) Compensated in accordance with the minimum wage laws of the Fair Labor Standards Act, 29 U.S.C. Sec. 206 as amended, 1966.

c. Personal Housekeeping Residents may be required to perform tasks of a personal housekeeping nature such as the making of one's own bed.

d. Payment to residents pursuant to this paragraph shall not be applied to the costs of institutionalization.

e. Staffing shall be sufficient so that the institution is not dependent upon the use of residents or volunteers for the care, maintenance or habilitation of other residents or for income-producing services. The institution shall formulate a written policy to protect the residents from exploitation when they are engaged in productive work.

34. A nourishing, well-balanced diet shall be provided each resident.

a. The diet for residents shall provide at a minimum the Recommended Daily Dietary Allowance as developed by the National Academy of Sciences. Menus shall be satisfying and shall provide the Recommended Daily Dietary Allowances. In developing such menus, the institution shall utilize the Moderate Cost Food Plan of the United States Department of Agriculture. The institution

shall not spend less per patient for raw food, including the value of donated food, than the most recent per person costs of the Moderate Cost Food Plan for the Southern Region of the United States, as compiled by the United States Department of Agriculture, for appropriate groupings of residents, discounted for any savings which might result from institutional procurement of such food.

b. Provision shall be made for special therapeutic diets and for substitutes at the request of the resident, or his guardian or next of kin, in accordance with the religious requirements of any resident's faith.

c. Denial of a nutritionally adequate diet shall not be used as punishment.

d. Residents, except for the non-mobile, shall eat or be fed in dining rooms.

35. Each resident shall have an adequate allowance of neat, clean, suitably fitting and seasonable clothing.

a. Each resident shall have his own clothing, which is properly and inconspicuously marked with his name, and he shall be kept dressed in this clothing. The institution has an obligation to supply an adequate allowance of clothing to any residents who do not have suitable clothing of their own. Residents shall have the opportunity to select from various types of neat, clean, and seasonable clothing. Such clothing shall be considered the resident's throughout his stay in the institution.

b. Clothing both in amount and type shall make it possible for residents to go out of doors in inclement weather, to go for trips or visits appropriately dressed, and to make a normal appearance in the community.

c. Nonambulatory residents shall be dressed daily in their own clothing, including shoes, unless contraindicated in written medical orders.

d. Washable clothing shall be designed for multiply [sic] handicapped residents being trained in self-help skills, in accordance with individual needs.

e. Clothing for incontinent residents shall be designed to foster comfortable sitting, crawling and/or walking, and toilet training.

f. A current inventory shall be kept of each resident's personal and clothing items.

g. The institution shall make provision for the adequate and regular laundering of the residents' clothing.

36. Each resident shall have the right to keep and use his own personal possessions except insofar as such clothes or personal possessions may be determined to be dangerous, either to himself or to others, by a Qualified Mental Retardation Professional.

37. a. Each resident shall be assisted in learning normal grooming practices with individual toilet articles, including soap and toothpaste, that are available to each resident.

b. Teeth shall be brushed daily with an effective dentifrice. Individual brushes shall be properly marked, used, and stored.

c. Each resident shall have a shower or tub bath, at least daily, unless medically contraindicated.

d. Residents shall be regularly scheduled for hair cutting and styling, in an individualized manner, by trained personnel.

e. For residents who require such assistance, cutting of toe nails and fingernails shall be scheduled at regular intervals.

38. Physical Facilities A resident has a right to a humane physical environment within the institutional facilities. These facilities shall be designed to make a positive contribution to the efficient attainment of the habilitation goals of the institution.

a. Resident Unit All ambulatory residents shall sleep in single rooms or in multi-resident rooms of no more than six persons. The number of nonambulatory residents in a multi-resident room shall not exceed ten persons. There shall be allocated a minimum of 80 square feet of floor space per resident in a multi-resident room. Screens or curtains shall be provided to ensure privacy. Single rooms shall have a minimum of 100 square feet of floor space. Each resident shall be furnished with a comfortable bed with adequate changes of linen, a closet or locker for his personal belongings, and appropriate furniture such as a chair and a bedside table, unless contraindicated by a Qualified Mental Retardation Professional who shall state the reasons for any such restriction.

b. Toilets and Lavatories There shall be one toilet and one lavatory for each six residents. A lavatory shall be provided with each toilet facility. The toilets shall be installed in separate stalls for ambulatory residents, or in curtained areas for nonambulatory residents, to ensure privacy, shall be clean and free of odor, and

shall be equipped with appropriate safety devices for the physically handicapped. Soap and towels and/or drying mechanisms shall be available in each lavatory. Toilet paper shall be available in each toilet facility.

c. Showers There shall be one tub or shower for each eight residents. If a central bathing area is provided, each tub or shower shall be divided by curtains to ensure privacy. Showers and tubs shall be equipped with adequate safety accessories.

d. Day Room The minimum day room area shall be 40 square feet per resident. Day rooms shall be attractive and adequately furnished with reading lamps, tables, chairs, television, radio and other recreational facilities. They shall be conveniently located to residents' bedrooms and shall have outside windows. There shall be at least one day room area on each bedroom floor in a multi-story facility. Areas used for corridor traffic shall not be counted as day room space; nor shall a chapel with fixed pews be counted as a day room area.

e. Dining Facilities The minimum dining room area shall be ten square feet per resident. The dining room shall be separate from the kitchen and shall be furnished with comfortable chairs and tables with hard, washable surfaces.

f. Linen Servicing and Handling The institution shall provide adequate facilities and equipment for the expeditious handling of clean and soiled bedding and other linen. There must be frequent changes of bedding and other linen, but in any event no less than every seven days, to assure sanitation and resident comfort. After soiling by an incontinent resident, bedding and

linen must be immediately changed and removed from the living unit. Soiled linen and laundry shall be removed from the living unit daily.

g. Housekeeping Regular housekeeping and maintenance procedures which will ensure that the institution is maintained in a safe, clean, and attractive condition shall be developed and implemented.

h. Nonambulatory Residents There must be special facilities for nonambulatory residents to assure their safety and comfort, including special fittings on toilets and wheelchairs. Appropriate provision shall be made to permit nonambulatory residents to communicate their needs to staff.

i. Physical Plant

(1) Pursuant to an established routine maintenance and repair program, the physical plant shall be kept in a continuous state of good repair and operation so as to ensure the health, comfort, safety and well-being of the residents and so as not to impede in any manner the habilitation programs of the residents.

(2) Adequate heating, air conditioning and ventilation systems and equipment shall be afforded to maintain temperatures and air changes which are required for the comfort of residents at all times. Ventilation systems shall be adequate to remove steam and offensive odors or to mask such odors. The temperature in the institution shall not exceed 83?F nor fall below 68?F.

(3) Thermostatically controlled hot water shall be provided in adequate quantities and maintained at the required temperature for resident use (110?F at the fixture) and for mechanical dishwashing and laundry use (180?F at the equipment). Thermostatically controlled hot water valves shall be equipped with a double valve system that provides both auditory and visual signals of valve failures.

(4) Adequate refuse facilities shall be provided so that solid waste, rubbish and other refuse will be collected and disposed of in a manner which will prohibit transmission of disease and not create a nuisance or fire hazard or provide a breeding place for rodents and insects.

(5) The physical facilities must meet all fire and safety standards established by the state and locality. In addition, the institution shall meet such provisions of the Life Safety Code of the National Fire Protection Association (21st edition, 1967) as are applicable to it.

V. Qualified Staff in Numbers Sufficient to Provide Adequate Habilitation

39. Each Qualified Mental Retardation Professional and each physician shall meet all licensing and certification requirements promulgated by the State of Alabama for persons engaged in private practice of the same profession elsewhere in Alabama. Other staff members shall meet the same licensing and certification requirements as persons who engage in private practice of their specialty elsewhere in Alabama.

a. All resident care workers who have not had prior clinical experience in a mental retardation

institution shall have suitable orientation training.

b. Staff members on all levels shall have suitable, regularly scheduled in-service training.

40. Each resident care worker shall be under the direct professional superversion [sic] of a Qualified Mental Retardation Professional.

41. Staffing Ratios

a. Qualified staff in numbers sufficient to administer adequate habilitation shall be provided. Such staffing shall include but not be limited to the following fulltime professional and special services. Qualified Mental Retardation Professionals trained in particular disciplines may in appropriate situations perform services or functions traditionally performed by members of other disciplines. Substantial changes in staff deployment may be made with the prior approval of this Court upon a clear and convincing demonstration that the proposed deviation from this staffing structure would enhance the habilitation of the residents. Professional staff shall possess the qualifications of Qualified Mental Retardation Professionals as defined herein unless expressly stated otherwise.

	Mild[4]	Moderate	Severe/ Profound
b. Unit	60	60	60
(1) Psychologists	1:60	1:60	1:60
(2) Social Workers	1:60	1:60	1:60
(3) Special Educators (shall include an equal number of master's degree and bachelor's degree holders in special education)	1:15	1:10	1:30
(4) Vocational Therapists	1:60	1:60	–
(5) Recreational Therapists (shall be master's degree graduates from an accredited program)	1:60	1:60	1:60
(6) Occupational Therapists	–	–	1:60
(7) Registered Nurses	1:60	1:60	1:12
(8) Resident Care Workers	1:2.5	1:1.25	1:1

The following professional staff shall be fulltime employees of the institution who shall not be assigned to a single unit but who shall be available to meet the needs of any resident of the institution:

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[4] See n. 2, supra.

Physicians	1:200
Physical Therapists	1:100
Speech & Hearing Therapists	1:100
Dentists[5]	1:200
Social Workers (shall be principally involved in the placement of residents in the community and shall include bachelor's degree graduates from an accredited program in social work)	1:80
Chaplains[6]	1:200

c. Qualified medical specialists of recognized professional ability shall be available for specialized care and consultation. Such specialist services shall include a psychiatrist on a one-day per week basis, a physiatrist [sic] on a two-day per week basis, and any other medical or health-related specialty available in the community.

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[5] Defendants may, in lieu of employing fulltime dentists, contract outside the institution for dental care. In this event the dental services provided the residents must include (a) complete dental examinations and appropriate corrective dental work for each resident each six months and (b) a dentist on call 24 hours per day for emergency work.

[6] Defendants may, in lieu of employing fulltime chaplains, recruit, upon the ratio shown above, interfaith volunteer chaplains.

VI. Miscellaneous

42. The guardian or next of kin of each resident shall promptly, upon resident's admission, receive a written copy of all the above standards for adequate habilitation. Each resident, if the resident is able to comprehend, shall promptly upon his admission be orally informed in clear language of the above standards and, where appropriate, be provided with a written copy.

43. The superintendent shall report in writing to the next of kin or guardian of the resident at least every six months on the resident's educational, vocational and living skills progress and medical condition. Such report shall also state any appropriate habilitation program which has not been afforded to the resident because of inadequate habilitation resources.

44. a. No resident shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without prior certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures.

b. No resident shall be subjected to a behavior modification program which attempts to extinguish socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only institutional convenience.

45. No resident shall have any of his organs removed for the purpose of transplantation without compliance with the procedures set forth in Standard 30,

supra, and after a court hearing on such transplantation in which the resident is represented by a guardian *ad litem*. This standard shall apply to any other surgical procedure which is undertaken for reasons other than therapeutic benefit to the resident.

46. Within 90 days of the date of this order, each resident of the institution shall be evaluated as to his mental, emotional, social, and physical condition. Such evaluation or reevaluation shall be conducted by an interdisciplinary team of Qualified Mental Retardation Professionals who shall use professionally recognized tests and examination procedures. Each resident's guardian, next of kin or legal representative shall be contacted and his readiness to make provisions for the resident's care in the community shall be ascertained. Each resident shall be returned to his family, if adequately habilitated, or assigned to the least restrictive habilitation setting.

47. Each resident discharged to the community shall have a program of transitional habilitation assistance.

48. The institution shall continue to suspend any new admissions of residents until all of the above standards of adequate habilitation have been met.

49. No person shall be admitted to any publicly supported residential instition [sic] caring for mentally retarded persons unless such institution meets the above standards.

APPENDIX B

PARTLOW HUMAN RIGHTS COMMITTEE

1. Ms. Harriet S. Tillman-Chairman – 3544 Brookwood Road, Birmingham, Alabama
2. Dr. J. W. Benton – 3008 Brook Hollow Lane, Birmingham, Alabama
3. Mr. Paul R. Davis – Tuscaloosa News, Tuscaloosa, Alabama 35401
4. Reverend Robert Keever – University Presbyterian Church, Tuscaloosa, Alabama 35401
5. Ms. Nancy Poole – 1836 Dorchester, Birmingham, Alabama
6. Mr. Eugene Ward – c/o Partlow State School and Hospital, Tuscaloosa, Alabama 35401
7. Ms. Estelle Witherspoon – Alberta, Alabama 36720

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT
OF ALABAMA, NORTHERN DIVISION

Ricky WYATT, by and through his aunt and legal guardian, Mrs. W. C. Rawlins, Jr., et al., for themselves jointly and severally and for all others similarly situated, Plaintiffs,

v.

Dr. Stonewall B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental

Health Officer, et al. Defendants,
United States of America et al., Amici Curiae.

CIVIL ACTION NO. 3195-N

On Request for Attorneys' Fees

Once again this Court is confronted with a request for attorneys' fees made by plaintiffs involved in *pro bono publico* litigation, and the request is well taken.[1] In 1967, over three years prior to the initiation of this suit, the American Association on Mental Deficiency [hereinafter referred to as AAMD] conducted a study of Partlow State School and Hospital.[2] That study, which was made available to Partlow's Director and to the State Mental Health Board, portrayed the institution as one enveloped by an atmosphere of despair, hopelessness and depression. The AAMD found Partlow grossly deficient virtually in every respect, including habilitation programming, staffing, staff training, community relations and residential facilities. At the time of the study, Partlow's administration and organization were found to be chaotic. The institution had promulgated no statement of its philosophy and objectives, and what emergency and safety procedures existed were evaluated as primitive and ineffective. Evidence offered at trial demonstrated that defendants also had knowledge prior to the initiation of this suit of the

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[1] Other such cases in which this Court has found a valid basis for the awarding of a reasonable attorneys' fee include *Sims v. Amos*, 336 F.Supp. 924 (M.D.Ala.1972) (three judges) and *NAACP v. Allen*, 340 F.Supp. 703 (M.D.Ala.1972).

[2] American Ass'n on Mental Deficiency Institutional Evaluation Project, Final Report For Partlow State School & Hospital (1967).

unconstitutionally substandard conditions at Bryce and Searcy Hospitals. Nevertheless, although many of the inadequacies known by defendants to exist in Alabama's mental health institutions could have been corrected without large expenditures, little, if any, progress toward upgrading conditions was realized until this case was initiated. From a legal standpoint, such nonfeasance on the part of defendants constitutes bad faith which necessitated the expense of litigation. This bad faith forms a valid basis for the granting of attorneys' fees. *See e. g., Vaughan v. Atkinson*, 369 U.S. 527, 530-531, 82 S.Ct. 997, 8 L.Ed.2d 88 (1961).

A second, and more appropriate, justification for the Court's award, however, evolves from a kind of benefit theory. *See Mills v. Electro Auto-Lite Co.*, 396 U.S. 375, 90 S.Ct. 616, 24 L.Ed.2d 593 (1970). Plaintiffs bringing suits to enforce a strong national policy often benefit a class of people far broader than those actually involved in the litigation. Such plaintiffs, who are said to act as "private attorneys general," *Newman v. Piggie Park Enterprises, Inc.*, 390 U.S. 400, 88 S.Ct. 964, 19 L.Ed.2d 1263 (1968), rarely recover significant damage awards. Moreover, if a violation of civil rights is alleged or if some other challenge to constituted authority is involved, these plaintiffs and their attorneys may confront other, more personal obstacles to the maintenance of their public-minded suits. *See NAACP v. Allen*, 340 F.Supp. 703 (M.D.Ala.1972). Consequently, in order to eliminate the impediments to *pro bono publico* litigation and to carry out congressional policy, an award of attorneys' fees not only is essential but also is legally required. *See Lee v. Southern Home Sites*, 444 F.2d 143 (5th Cir. 1971); *Sims v. Amos*, 336 F.Supp. 924

(M.D.Ala.1972); *NAACP v. Allen, supra; Bradley v. School Bd. of Richmond,* 53 F.R.D. 28 (E.D.Va.1971).

The present action clearly is one intended to be encouraged by the benefit rule. By successfully prosecuting this suit, plaintiffs have benefitted not only the present residents of Bryce, Partlow and Searcy but also everyone who will be confined to those institutions in the future. Veritably, it is no overstatement to assert that all of Alabama's citizens have profited and will continue to profit from this litigation. So prevalent are mental disorders in our society that no family is immune from their perilous incursion. Consequently, the availability of institutions capable of dealing successfully with such disorders is essential and, of course, in the best interest of all Alabamians.

Despite plaintiffs' having benefitted so many people, however, they neither sought nor recovered any damages. Nevertheless, the expenses they incurred in vindicating the public good were considerable. To burden only plaintiffs with these costs not only is unfair but also is legally impermissible. *See e. g., Mills v. Electro Auto-Lite Co., supra; Lee v. Southern Home Sites, supra.* Considerations of equity require that those who profit share the expense. In this case, the most logical way to spread the burden among those benefitted is to grant attorneys' fees. Plaintiffs clearly are entitled to a reasonable award.

This Court must consider, therefore, what is reasonable under the circumstances. Factors relevant to the Court's determination generally are the same as those covering grants of attorneys' fees in commercial cases. *See Bradley v. School Bd. of Richmond, supra.* They include the

intricacy of the case and the difficulty of proof, the time reasonably expended in the preparation and trial of the case, the degree of competence displayed by the attorneys seeking compensation and the measure of success achieved by these attorneys. In public interest cases, courts also should consider the benefit inuring to the public, the personal hardships that bringing this kind of litigation causes plaintiffs and their lawyers, and the added responsibility of representing a class rather than only individual plaintiffs.

Having considered these factors, the Court notes that the several aspects of the present litigation have synthesized to compose a very complex case. Plaintiffs' attorneys have navigated through a heretofore uncharted course and, in the process, have helped establish minimum constitutional standards for mental health institutions. These attorneys have exhibited professional conscientiousness throughout the litigation, and their toil, along with that of others, has culminated in an incalculable benefit to the people of Alabama.[3]

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[3] The able and invaluable assistance which plaintiffs' attorneys received from amici in this case in no way detracts from the quality of their effort. The Court is constrained, however, to comment generally on the number of lawyers for whom plaintiffs seek attorneys' fees. Because this case is so complex and the time required to meet various deadlines so great, the Court feels that the number of lawyers utilized by plaintiffs was necessary. In another case in which attorneys' fees are appropriate, the same may not be true. The Court must decide on an ad hoc basis whether the number of attorneys employed and the time expended by them were reasonable.

The above considerations, and others, militate in favor of the Court's granting plaintiffs' attorneys full compensation. Nevertheless, the weight of these factors must be balanced against and tempered by the nature of this lawsuit. It is the duty of members of the legal profession to represent clients who are unable to pay for counsel and also to bring suits in the public interest. While lawyers who satisfy this ethical responsibility should be remunerated, their fees should not be exorbitant. This Court must bear in mind that the very goals plaintiffs' attorneys seek to achieve through litigation require great monetary outlays, most of which presently are unavailable. Some compromise, therefore, is essential.

In attempting to determine what is a reasonable fee under the circumstances, this Court is impressed with the philosophy underlying the Criminal Justice Act. That Act provides for compensation to attorneys appointed to represent indigent criminal defendants. The Act's legislative history makes clear that although the amount provided, $30 per in-court hour and $20 per out-of-court hour, is below normal levels of compensation in legal practice, it nevertheless is considered a reasonable basis upon which lawyers can carry out their professional responsibility without either personal profiteering or undue financial sacrifice. 1964 U.S.Code Cong. & Admin. News, p. 2997.

The Court is convinced that this philosophy applies with equal force to the present case. As already emphasized, lawyers participating in the case *sub judice*, as well as those participating in a Criminal Justice Act case, perform ethical and professional responsibilities. In both cases they embark upon their participation with knowledge that their named clients are unable to pay them.

Generally, however, these lawyers are not motivated by desire for profit but by public spirit and sense of duty. Moreover, in both cases the rights involved, those dealing with restrictions on physical freedom, are of the most profound significance to the public. These similarities justify referral to the Criminal Justice Act.

On the basis of the fee schedule set forth in the Act, therefore, this Court has determined that a reasonable fee in this case is $30 per in-court hour and $20 per out-of-court hour.[4] In establishing this fee, however, the Court is careful to note that the Criminal Justice Act furnishes only a very flexible standard. In a particular case, a reasonable fee may vary either way from that provided by the Act.

In addition to determining an hourly fee, the Court is obliged to decide what time is reasonable for an attorney or attorneys to have spent in connection with the lawsuit. Plaintiffs' lawyers, Jack Drake and Reber Boult, have filed statements setting forth in detail their time expended in preparation of the case. The hours they have claimed are reasonable and uncontested. Plaintiffs' other lawyer, George Dean, however, has neglected to file a similar statement. Instead, he has testified only that he has spent almost all of 18 months working on the case. Under such circumstances, the Court must decide the amount of time an attorney should reasonably have spent to accomplish the work produced. From the evidence adduced at the

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[4] In addition to regularly employed legal staff, defendants retained special counsel in this case at a rate of $30 per hour.

hearing on this matter, the Court has made that determination.

Accordingly, it is the order, judgment and decree of this Court:

1. That attorney's fees and expenses of the Honorable George Dean in the amount of $23,600.00 be and the same are hereby taxed against defendant Alabama Mental Health Board;

2. That attorney's fees and expenses of the Honorable Jack Drake in the amount of $7,595.91 be and the same are hereby taxed against defendant Alabama Mental Health Board; and

3. That attorney's fees and expenses of the Honorable Reber Boult in the amount of $5,558.71 be and the same are hereby taxed against defendant Alabama Mental Health Board.

It is further ordered that defendant Alabama Mental Health Board pay said expenses and attorneys' fees to the Clerk of this Court within 30 days from this date. Upon receipt of these funds, the Clerk of this Court will deposit them in an interest bearing account. The Clerk of this Court is ordered and directed to hold said funds in said interest bearing account pending further order of this Court.

Ricky WYATT, by and through his Aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., Plaintiffs,

v.

Dr. Stonewall B. STICKNEY, as Commissioner of Mental Health and the State of Alabama Mental Health Officer, et al., Defendants, United States of America, et al., Amici Curiae.

Civ. A. No. 3195-N.
United States District Court,
M. D. Alabama, N. D.
Dec. 10, 1971.

George W. Dean, Jr., Destin, Fla., and Jack Drake, University, Ala., for the plaintiffs.

William J. Baxley, Atty. Gen., and Gordon Madison and J. Jerry Wood, Asst. Attys. Gen., State of Alabama, Montgomery, Ala., for the defendants.

David L. Norman, Asst. Atty. Gen., Civil Rights Div., Dept. of Justice, Washington, D. C., and Ira DeMent, U. S. Atty., Montgomery, Ala., for amicus curiae, The United States of America.

James F. Fitzpatrick, Jeffery D. Bauman and Stephen M. Sacks, of Arnold & Porter, Washington, D. C., Charles R. Halpern, Washington, D. C., and Bruce J. Ennis, New York City, for amici curiae the American Psychological Assn., American Orthopsychiatric Assn., and American Civil Liberties Union.

ORDER

JOHNSON, Chief Judge.

In this class action, originally filed in behalf of patients involuntarily confined for mental treatment purposes at Bryce Hospital, Tuscaloosa, Alabama,[1] this Court on March 12, 1971, in a formal opinion and decree, 325 F.Supp. 781, among other things, held:

> The patients at Bryce Hospital, for the most part, were involuntarily committed through non-criminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings. When patients are so committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition. . . .
>
> Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense." *Ragsdale v. Overholser,* 108 U.S.App.D.C. 308 [315], 281 F.2d 943, 950 (1960). The purpose of involuntary hospitalization for treatment purposes is *treatment* and not mere

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[1] On August 22, 1971, this Court granted plaintiffs' proposed amendment to enlarge the class to include patients involuntarily confined for mental treatment purposes at Partlow State School and Hospital and Searcy Hospital at Mt. Vernon, Alabama. This did not necessitate additional defendants since by authority of Title 22, Section 318, Code of Alabama, the defendant board has control and jurisdiction of all the mental institutions herein involved.

> custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions. . . .

At the request of defendants, the Court in the March 1971 order allowed defendants six months to set standards and implement fully a treatment program so as to give each treatable patient a realistic opportunity to be cured or to improve his or her mental condition. The case is again submitted upon defendants' reports and the several objections thereto.[2]

In the matters presented to this Court by the parties, there seem to be three fundamental conditions for adequate and effective treatment programs in public mental institutions. These three fundamental conditions are: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. The report filed by defendants with this Court, as well as the reports and objections of other parties who have studied the conditions at Bryce Hospital, demonstrates rather conclusively that the hospital is deficient in all three of these fundamental respects.

The psychological and physical environment problems are, in some instances, interrelated. For example, the

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[2] As directed, the United States of America formally appeared as amicus curiae. By leave of the Court the American Psychological Association, the American Ortho-psychiatric Association, and the American Civil Liberties Union have also appeared as amici curiae. The plaintiffs and all amici have filed objections to defendants' reports.

dormitories are barn-like structures with no privacy for the patients. For most patients there is not even a space provided which he can think of as his own. The toilets in restrooms seldom have partitions between them. These are dehumanizing factors which degenerate the patients' self esteem. Also contributing to the poor psychological environment are the shoddy wearing apparel furnished the patients, the non-therapeutic work assigned to patients (mostly compulsory, uncompensated housekeeping chores), and the degrading and humiliating admissions procedure which creates in the patient an impression of the hospital as a prison or as a "crazy house". Other conditions which render the physical environment at Bryce critically substandard are extreme ventilation problems, fire and other emergency hazards, and overcrowding caused to some degree by poor utilization of space. In addition, the quality of the food served the patients is inferior. Only fifty cents per patient per day is spent for food, and sanitation procedures with regard to the preparation and service of food, commonly recognized as basic health practices and utilized at other such hospitals, are not followed at Bryce.

The second fundamental condition needed for effective treatment is a qualified and numerically sufficient staff. It is clear from the reports of Bryce's expert consultants that Bryce is wholly deficient in this area, both as regards its professional staff and its nonprofessional staff. More psychiatrists, Doctor of Philosophy level psychologists and qualified Medical Doctors are not only a medical but are also a constitutional necessity in this public institution. Special staff is needed to place the custodial patients still residing at Bryce. Although, as *Rouse v.*

Cameron, 125 U.S.App.D.C. 366, 373 F.2d 451 (1966) points out, contact with the nonprofessional staff should be therapeutic, very little of this therapeutic value is realized at Bryce. The nonprofessional staff is poorly trained; nurses aides, for example, are required to have only a tenth grade education. Also there is no effective "in-service" training program for, or even any regular supervision over, the nonprofessional staff. The nonprofessionals are spread very thinly; thus, they are overworked, creating not only an inadequate situation for the patients but extreme stresses for individual aides. Both Bryce consultants agree with amici and plaintiffs that additional aides and activities therapists are a necessity.

The third necessary condition for an effective treatment program is individualized treatment plans. Bryce is also deficient in this area. Although every patient has been classified as to treatability, the records made on each patient are inadequate. Minimum medical standards require that periodic inquiries be made into the needs of the patients with a view toward providing suitable treatment for them. Yet, at Bryce the records evidence no notations of mental change. They consist generally only of notations of the times and amounts of drugs given and participation in the Patient Operated Program, the Token Economy Program or the Level Program. Bryce's own consultant advises that treatment is geared primarily to housekeeping functions. The three main programs which have been implemented motivate the patients to some activity and do effect some degree of socialization, but at a minimum level. What programs there are do not yet seem to be operating effectively, partly because of the untrained staff members supervising them.

All the objections raised by amici and by plaintiffs generally are supported by the reports of Bryce's consultants. There seems to be a consensus of opinion among the experts that the treatment program at Bryce Hospital continues to be wholly inadequate. There are strong indications from the evidence before the Court, sparse as it is, that the conditions at Partlow and Searcy are no better than those at Bryce.

The primary and fundamental question remaining in this case, therefore, is not whether the defendants have promulgated and implemented a program that meets minimum medical and constitutional standards, but what procedure this Court should now pursue to ensure that this be done.[3] Although the goals defendants have set are rather vague, the defendants Stickney and Folsom, who has since the earlier hearing in this cause been retained as Superintendent of Bryce Hospital, have to this point generally demonstrated good faith and a desire to attain minimum medical and constitutional standards in the three primary mental institutions now operated by the State of Alabama. Consequently this Court will again

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[3] As stated earlier, the treatment program now being implemented at Bryce is wholly inadequate. Likewise, the interim report filed by defendants on June 10, 1971, is inadequate. This report and the other matters presented to this Court upon this submission affirmatively reflect that defendants have formulated no standards for staffing, for improving the physical environment or for realistically improved treatment plans. While it may be that adequate financial means had not at the time of the filing of defendants' reports been made available by the Alabama Legislature to satisfy these medically and constitutionally mandated standards, the standards should at least have been formulated.

defer turning over the operation of these institutions to a panel of masters.

Nonetheless, minimum medical and constitutional standards for the operation of these institutions must be formulated. Defendants have been given an opportunity to perform this task and have failed. It must be kept in mind that plaintiffs' rights are present ones, and they must be not only declared but secured at the earliest practicable date. This Court has concluded that the most feasible procedure to be followed as to this phase of the litigation is for this matter to be set again for formal hearing, this time for the purpose of allowing the parties and amici the opportunity to present proposed standards that meet medical and constitutional requirements for the operation of the three mental institutions herein concerned and to present evidence by experts in support thereof. From this evidence this Court will establish standards and in due course order their implementation.

Accordingly, it is the order, judgment and decree of this Court that this cause be and the same is hereby set for hearing for the purposes hereinabove stated commencing at 10:00 a. m. on January 18, 1972.

Ricky WYATT, by and through his Aunt and legal guardian Mrs. W. C. Rawlins, Jr., et al., Plaintiffs,

v.

Dr. Stonewall B. STICKNEY, as Commissioner or [sic] Mental Health and the State of Alabama Mental Health Officer, et al., Defendants.

Civ. A. No. 3195-N.
United States District Court, M.D. Alabama, N.D.
March 12, 1971.

George W. Dean, Jr., Destin, Fla., for plaintiffs.

Joseph D. Phelps, of Hill, Robison, Belser, Brewer & Phelps, Montgomery, Ala., and Jerry Wood, Asst. Atty. Gen., Montgomery, Ala., for defendants.

ORDER

JOHNSON, Chief Judge.

This is a class action that was initiated by guardians of patients confined at Bryce Hospital, Tuscaloosa, Alabama, and by certain employees of the Alabama Mental Health Board who are assigned to Bryce Hospital. The plaintiffs sue on behalf of themselves and on behalf of other members of their respective classes.[1]

The defendants are the commissioner and the deputy commissioner of the Department of Mental Health of the State of Alabama, the members of the Alabama Mental

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[1] Plaintiff-employees have now withdrawn their request that they be reinstated as employees of the Alabama Mental Health Board. This completely eliminates their reinstatement claims from the case.

Health Board, the Governor of the State of Alabama, and the probate judge of Montgomery County, Alabama, as representative of the other judges of probate in the State of Alabama.

The case is now submitted upon plaintiffs' motion for a preliminary injunction, the opposition of the defendants thereto, and the testimony taken in connection with the hearing on plaintiffs' motion.

The Alabama Mental Health Board is a public corporation created by the State of Alabama through legislation codified at Title 22, Sections 311-336, Alabama Code (Supplement 1969). This board is responsible for the administration of all State mental health facilities and treatment centers, including Bryce Hospital, Tuscaloosa, Alabama. When not in session the Alabama Mental Health Board acts through its chief administrative officer whose title is State Mental Health Officer. This position is presently held by Dr. Stonewall B. Stickney.[2]

Bryce Hospital is located in Tuscaloosa, Alabama, and is a part of the mental health service delivery system

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[2] The Alabama Mental Health Board is also responsible for other State mental health facilities, such as that located at Search Hospital, Mont [sic] Vernon, Alabama. However, in this case this Court is not concerned with the operation of the facility at Searcy, since plaintiffs have not properly raised the 'adequacy of treatment' afforded by the State of Alabama to patients at Search [sic] Hospital. Plaintiffs, in their post-trial briefs, argue that they have properly raised the 'adequacy of treatment' afforded the patients at Searcy Hospital; however, this Court finds that the defendants were not fairly apprised that plaintiffs intended to include Searcy and the pleadings in this case do not so reflect.

for the State of Alabama. Bryce Hospital has approximately 5,000 patients, the majority of whom are involuntarily committed through civil proceedings by the various probate judges in Alabama. Approximately 1,600 employees were assigned to various duties at the Bryce Hospital facility when this case was heard on plaintiffs' motion for a preliminary injunction.

During October 1970, the Alabama Mental Health Board and the administration of the Department of Mental Health terminated 99 of these employees. These terminations were made due to budgetary considerations and, according to the evidence, were necessary to bring the expenditures at Bryce Hospital within the framework of available resources. This budget cut at Bryce Hospital was allegedly necessary because of a reduction in the tax revenues available to the Department of Mental Health of the State of Alabama, and also because an adjustment in the pay periods for personnel which had been directed by the Alabama legislature would require additional expenditures. The employees who were terminated included 41 persons who were assigned to duties such as food service, maintenance, typing, and other functional duties not involving direct patient care in the hospital therapeutic programs. Twenty-six persons were discharged who were involved in patient activity and recreational programs. These workers were involved in planning social and other types of recreational programs for the patient population. The remaining 32 employees who were discharged included 9 in the department of psychology, 11 in the social service department, with varying degrees of educational background and experience, three registered nurses, who [sic] physicians, one dentist and six dental

aides. After the termination of these employees, there remained at Bryce Hospital 17 physicians, approximately 850 psychiatric aides, 21 registered nurses, 12 patient activity workers, and 12 psychologists with varying academic qualifications and experience, together with 13 social service workers. Of the employees remaining whose duties involved direct patient care in the hospital therapeutic programs, there are only one Ph.D. clinical psychologist, three medical doctors with some psychiatric training (including one board eligible but no board-certified psychiatrist) and two M.S.W. social workers.

The Alabama Department of Mental Health, during the last two and one-half years, has been engaged in rather extensive reorganization. This reorganizational effort, according to testimony, is designed to render a more efficient and effective delivery of treatment to patients at Bryce Hospital and in the other mental hospitals[3] within the Alabama Mental Health system. A part of the organizational effort was a transition from a departmental system of organization at Bryce Hospital to the unit-team system of delivery of mental health services and treatment to patients at Bryce Hospital. The unit-team system, as it is termed, divides the State of Alabama into contiguous geographical county units, with mentally ill patients from each such geographical area being assigned to a particular unit within the hospital. This geographical distribution is divided between Searcy and Bryce Hospitals, with Search [sic] accommodating the counties in the southerly part of the State and Bryce in the remainder of the State. Approximately ten units are

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[3] Searcy, located at Mount Vernon, Alabama.

ultimately planned for the Bryce facility. The unit is to be headed by a team leader who will normally be a professional. It is proposed that the units contain such professionals as physicians, psychologists, and social workers, as well as psychiatric aides and nurses. The patients within the unit are to receive individual attention from such hospital personnel according to their needs. This Court cannot now say upon the evidence that has been presented that the decision of the Alabama Department of Mental Health to adopt the unit-team treatment delivery approach was an improper exercise of medical and professional judgment. The evidence is clear that the unit-team approach is a scientifically recognized and acceptable method of delivering treatment to mental health patients. It seems to be a nationally recognized method for the improvement of the delivery of therapeutic services to patients in mental hospitals. This Court is unable at this time to evaluate the therapeutic effectiveness of the unit-team delivery approach at Bryce Hospital. This is true due to the fact that at the time of the hearing upon plaintiffs' motion for a preliminary injunction the transition had only just been completed, but not fully implemented.

Included in the Bryce Hospital patient population are between 1,500 and 1,600 geriatric patients who are provided custodial care but no treatment. The evidence is without dispute that these patients are not properly confined at Bryce Hospital since these geriatric patients cannot benefit from any psychiatric treatment or are not mentally ill. Also included in the Bryce patient population are approximately 1,000 mental retardates, most of whom receive only custodial care without any psychiatric

treatment. Thus, the evidence reflects that there is considerable confusion regarding the primary mission and function of Bryce Hospital since certain nonpsychotic geriatric patients and the mental retardates, and perhaps other nonmentally ill persons, have been and remain committed there for a variety of reasons.

The evidence further reflects that Alabama ranks fiftieth among all the states in the Union in per-patient expenditures per day.[4] This Court must, and does, find from the evidence that the programs of treatment in use at Bryce Hospital prior to the reorganization that has resulted in the unit-team approach were scientifically and medically inadequate. These programs of treatment failed to conform to any known minimums established for providing treatment for the mentally ill.

The patients at Bryce Hospital, for the most part, were involuntarily committed through noncriminal procedures and without the constitutional protections that are afforded defendants in criminal proceedings. When patients are so committed for treatment purposes they unquestionably have a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition. *Rouse v. Cameron*, 125 U.S.App.D.C. 366, 373

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[4] No evidence was presented on the point, but the plaintiffs in their post-trial brief advised this Court that Bryce Hospital has not conformed with the standards of the Social Security Administration to the point of becoming eligibile for federal funds under the Medicare and Medicaid programs. Plaintiffs' counsel further advised in their brief that Bryce Hospital had not applied for certification for eligibility for these funds.

F.2d 451; *Covington v. Harris,* 136 U.S.App.D.C. 35, 419 F.2d 617. Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed 'into a penitentiary where one could be held indefinitely for no convicted offense.' *Ragsdale v. Overholser,* 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (1960). The purpose of involuntary hospitalization for treatment purposes is treatment and not mere custodial care or punishment. This is the only justification, from a constitutional standpoint, that allows civil commitments to mental institutions such as Bryce. According to the evidence in this case, the failure of Bryce Hospital to supply adequate treatment is due to a lack of operating funds. The failure to provide suitable and adequate treatment to the mentally ill cannot be justified by lack of staff or facilities. *Rouse v. Cameron,* supra. In *Rouse* the Court stated:

We are aware that shortage of psychiatric personnel is a most serious problem today in the care of the mentally ill. In the opinion of the American can [sic] Psychiatric Association no tax-supported hospital in the United States can be considered adequately staffed. We also recognize that shortage cannot be remedied immediately. But indefinite delay cannot be approved. 'The rights here asserted are * * * present rights * * * and, unless there is an overwhelming compelling reason, they are to be promptly fulfilled.' *Watson v. City of Memphis,* 373 U.S. 526, 533, (83 S.Ct. 1314, 1318, 10 L.Ed.2d 529) (1963). (Emphasis in original.)

There can be no legal (or moral) justification for the State of Alabama's failing to afford treatment – and adequate treatment from a medical standpoint – to the several thousand patients who have been civilly committed

to Bryce's for treatment purposes. To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process.

As stated, this Court cannot at this time make any finding with regard to whether the unit-team system approach or the departmental approach is a better treatment delivery mechanism for Bryce Hospital. Nor can this Court at this time make any finding regarding the 'adequacy' of the treatment to be given under the unit-team approach. It may very well be that when the unit-team approach is implemented in the Bryce facility the patients committed there will be receiving such individual treatment as will give each of them a realistic opportunity to be cured or to improve his mental condition. On the other hand, it may be that the unit-team approach will not provide such treatment.

The plaintiffs by formal motion ask this Court for an order of reference in order that there may be an authoritative determination of standards of the adequacy of the mental treatment now used and to be used in effectuating the right to treatment for those who are incarcerated in the Bryce facility. The defendants oppose this Court's making such an order of reference at this time, arguing that it is only proper that the defendants be allowed the opportunity to set standards and to make evaluations for submission to the Court prior to the time this Court appoints masters to perform this task. This Court has concluded that it will, for the time being, reserve ruling upon plaintiffs' motion for an order of reference. The

reservation upon plaintiffs' motion for an order of reference will be for a limited time so as to afford the defendants an opportunity to promulgate and implement proper standards for the adequate mental care of the patients in the Bryce Hospital facility and in order to allow the defendants a reasonable time to implement fully the unit-team approach and to measure the effectiveness of the unit-team therapeutic treatment programs at the Bryce facility. This Court recognizes that this is a matter which will take thorough study and will require professional judgment and evaluation. The evidence reflects that the defendant Dr. Stonewall B. Stickney is, if he is afforded adequate funds for staffing and facilities, qualified to study, to evaluate, to institute, and to implement fully appropriate mental health treatment programs. A failure on the part of the defendants to implement fully, within six months from the date of this order, a treatment program so as to give each of the treatable patients committed to Bryce facility a realistic opportunity to be cured or to improve his or her mental condition, will necessitate this Court's appointing a panel of experts in the area of mental health to determine what objective and subjective hospital standards will be required to furnish adequate treatment to the treatable mentally ill in the Bryce facility. This will include an order requiring a full inspection of the existing facilities, a study of the operational and treatment practices and programs, and recommendations that will enable this Court to determine what will be necessary in order to render the Bryce facilities a mental health unit providing adequate and effective treatment, in a constitutional

sense, for the patients who have been involuntarily committed and are confined there.

Accordingly, it is the order, judgment and decree of this Court that the defendants, within ninety days from the date hereof, prepare and file with this Court:

a. A precise definition of the mission and functions of Bryce Hospital;

b. A specific plan whereby appropriate and adequate treatment will be provided to the patients at Bryce Hospital who, from a medical standpoint, may be responsive to mental health treatment;

c. A report reflecting in detail the progress on the implementation of the unit-team approach in the Bryce facility. This report should reflect the number of unit teams, the number of patients in each unit, a breakdown of professionals assigned to each unit by discipline, and the number of patients in each unit who are receiving individual attention from some member of the professional disciplines and how often this treatment is accorded.

In this connection, records are to be maintained detailing the names of the patients entitled to receive – from a medical standpoint – psychiatric care and treatment, and the type and extent of the treatment being administered. Such reports must be made available to plaintiffs' attorneys and to the attorneys of any other parties who may appear in this case as amicus.

It is further ordered that the United States of America, acting through the United States Department of Justice and other appropriate officials such as the officials of

the United States Department of Health, Education and Welfare, be and it is hereby requested and invited to appear in this cause as amicus for the purpose of assisting this Court in evaluating the treatment programs at the Bryce Hospital facility and in assisting the defendants in meeting the subjective standards of the United States Department of Health, Education and Welfare as said standards pertain to adequate treatment, personnel, space, equipment and facilities. The Department of Health, Education and Welfare and the United States Public Health Service are also requested and invited to participate, through the United States Department of Justice, as amicus, in order to assist the defendants in qualifying for Social Security benefits for the approximately 1,500 to 1,600 geriatric patients who are presently housed at Bryce Hospital for custodial purposes; this invitation to these agencies is also for the purpose of rendering assistance to the defendants in formulating and implementing a feasible plan that will benefit each of these geriatric patients by his or her becoming appropriately situated in some type facility other than a facility for the treatment of the mentally ill.

It is further ordered that ruling on plaintiffs' motion for an order of reference be and the same is hereby reserved.

This Court specifically retains jurisdiction of this case.

IN THE UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

RICKY WYATT, by and through his aunt and legal guardian, MRS. W.C. RAWLINS, JR., et al., Plaintiffs,	)	
DIANE MARTIN, et al., Plaintiff-Intervenors,	)	Civil Action No. 3195-N
vs.	)	
RICHARD HANAN, as Commissioner of Mental Health and Mental Retardation and the State of Alabama Mental Health Officer, et al., Defendants.	)	
UNITED STATES OF AMERICA, Amicus Curiae.	)	

MOTION FOR INTERVENTION

The seven class members identified below move this Court for leave to intervene as named plaintiffs in this action.[1]

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[1] "It is firmly established that where a class action exists, members of the class may . . . be substituted as named plaintiffs . . . after the claims of the original named plaintiffs are rendered moot." *Graves v. Walton County Board of Education*, 686 F.2d 1135, 1138 (5th Cir. 1982) (Unit B).

These class members seek leave to intervene without prejudice to defendants' motion to recertify, modify, or decertify the plaintiff class (doc. #417). It is plaintiffs' understanding that the Court will address defendants' motion after hearing evidence at the upcoming trial. *See* Order of March 9, 1995 (doc. #696).

The class members seeking to intervene are:[2]

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[2] Apparently, there is a named class representative with a "live" claim, Mr. Benny Blankenship. *See* Order of March 2, 1979 (granting motion of Benny Blankenship and others to be designated as additional representatives of the plaintiff class, according to the clerk's docket). Plaintiffs' counsel have been trying to communicate by telephone with Mr. Blankenship, currently a patient at the Thomasville facility. Defendants and their counsel, however, have attempted to thwart plaintiffs' efforts at every turn. At first, they refused to confirm whether Mr. Blankenship was still a patient at Thomasville. Then, they informed plaintiffs that he was on a trial visit from the facility, and refused to disclose Mr. Blankenship's whereabouts on the grounds that the information was "confidential" and Mr. Blankenship's guardian had not consented to release of the information. Apparently, Mr. Blankenship's sister, whom Mr. Blankenship was visiting, was eventually informed that plaintiffs' counsel had called. She called plaintiffs' counsel yesterday, and counsel talked with her today. She informed plaintiffs that Mr. Blankenship has no guardian, and she encouraged counsel to speak with Mr. Blankenship after he returned today to Thomasville. Mr. Blankenship has apparently never been informed that plaintiffs' counsel are attempting to reach him. (Plaintiffs assume, but have not yet confirmed, that the Benny Blankenship who is a patient at Thomasville is the same Benny Blankenship who is a named plaintiff.)

Individuals with Mental Illness

Robert Hanna

1. Plaintiff Robert Hanna, age 28, was admitted to Searcy Hospital on May 3, 1991. He has diagnoses of, among other things, schizophrenia, borderline intellectual functioning, and cerebral palsy.

2. Mr. Hanna is being denied minimally adequate treatment and care.

3. Mr. Hanna receives no treatment other than medication. He is provided virtually no therapeutic activities, and spends most of his days on the ward with nothing to do.

4. Defendants have failed to provide Mr. Hanna with a safe and humane environment, including adequate supervision. Mr. Hanna has been repeatedly assaulted by staff and other patients. During a period he was supposed to receive one-to-one staffing, Mr. Hanna eloped from the Searcy Hospital and was found wondering along the highway, Mr. Hanna has gained access to an unlocked janitorial closet and ingested cleaning fluid. While on one-to-one suicide watch, Mr. Hanna obtained a pop top from a soda can and cut his wrists.

5. Defendants have failed to adjust Mr. Hanna's medications, despite the fact that the medications are not effectively alleviating his symptoms.

6. Defendants are violating Mr. Hanna's rights under the U.S. Constitution and the *Wyatt* Standards.

Gregory Woelke

7. Plaintiff Gregory Woelke, age 47, has been hospitalized at Bryce Hospital since February 28, 1994. He has a diagnosis of organic personality disorder.

8. Mr. Woelke is being denied minimally adequate treatment and care.

9. Mr. Woelke receives no treatment other than medication. He is provided virtually no therapeutic activities, and spends most of his days on the ward with nothing to do.

10. Mr. Woelke has been abused verbally by staff.

11. Defendants determined Mr. Woelke was ready for community placement in September 1994, and referred him for placement. Mr. Woelke, although labelled mentally ill, is not dangerous to himself or others. Nevertheless, he has not been discharged. Mr. Woelke remains hospitalized at Bryce because of, among other things, a lack of community services.

12. Defendants are violating Mr. Woelke's rights under the U.S. Constitution, the *Wyatt* Standards, and the Americans with Disabilities Act.

Jean Washington

13. Plaintiff Jean Washington, age 44, was admitted to Searcy Hospital on November 18, 1992. She has a diagnosis of schizoaffective disorder.

14. Ms. Washington is being denied minimally adequate treatment and care.

15. Ms. Washington receives no treatment other than medication. She is provided virtually no therapeutic activities, and spends most of her days on the ward with nothing to do.

16. Ms. Washington is being denied adequate medical care. She is not receiving treatment for serious side effects of her medication.

17. Although Ms. Washington requires community placement, defendants have failed to provide her community services. Defendants are apparently denying Ms. Washington community services because she is "obsessed" with discharge. Defendants are failing to serve Ms. Washington in the least restrictive setting appropriate to her needs.

18. Defendants are violating Ms. Washington's rights under the U.S. Constitution, the *Wyatt* Standards, and the Americans with Disabilities Act.

Brent Bugsch

19. Brent Bugsch, age 25, was admitted to Searcy Hospital on November 10, 1993.

20. Mr. Bugsch is being denied minimally adequate treatment and care.

21. Mr. Bugsch receives no treatment other than medication, which has not been effective. He is provided virtually no therapeutic activities, and spends most of his days on the ward with nothing to do.

22. There is a standing order (*i.e.*, a "PRN" order) in Mr. Bugsch's chart that he is to be restrained if he refuses or resists taking his medications.

23. Defendants have failed to adjust Mr. Bugsch's medications, despite the fact that the medications are not effectively alleviating his symptoms. In addition, Mr. Bugsch is receiving high doses of psychoactive medication without adequate medical monitoring.

24. Defendants are violating Mr. Bugsch's rights under the U.S. Constitution and the *Wyatt* Standards.

Benjamin Stokes

25. Plaintiff Benjamin Stokes, age 30, was admitted to Searcy Hospital on August 26, 1993. Mr. Stokes has a diagnosis of schizophrenia.

26. Mr. Stokes is being denied minimally adequate treatment and care.

27. Mr. Stokes receives no treatment other than medication. He is provided virtually no therapeutic activities, and spends most of his days on the ward with nothing to do.

28. Defendants have failed to adjust Mr. Stokes' medications, despite the fact that the medications are not effectively alleviating his symptoms.

29. Mr. Stokes' current admission is his fifth to Searcy. When he was discharged in the past, defendants failed to ensure he was provided adequate transitional care and treatment.

30. Defendants are violating Mr. Stokes' rights under the U.S. Constitution and the *Wyatt* Standards.

Individuals with Mental Retardation

Stephanie Ramsey

31. Plaintiff Stephanie Ramsey, age 30, is profoundly mentally retarded. She was admitted to the Ireland Developmental Center on August 12, 1986, after living at home until age 23. She sues by her next friend and mother, Geraldine Ramsey.

32. Ms. Ramsey is alert and responsive to her environment. She is also able to take care of her self-help needs with minimal prompting, but like many other plaintiffs has care needs related to dressing bathing and grooming. Defendants characterize Ms. Ramsey as self-abusive, but she exhibits few behavioral problems during frequent visits home.

33. Ms. Ramsey is being denied minimally adequate habilitation and care.

34. Defendants has failed to provide Ms. Ramsey with a safe and humane environment. She has suffered multiple, unexplained injuries as a resident at Glenn Ireland. During an eighteen-month time-period in 1993 and 1994, for example, Ms. Ramsey had approximately 150 injuries, including fractures, lacerations, and bruises. She has been abused by Ireland staff.

35. Defendants are denying Ms. Ramsey's right to habilitation in the least restrictive setting for her, an integrated community program. Although community

services would have made Ms. Ramsey's institutionalization unnecessary, defendants never informed Ms. Ramsey's family that such alternative might be available. Defendants have also actively discouraged Ms. Ramsey's family from pursuing community care for Ms. Ramsey.

36. Defendants are violating Ms. Ramsey's rights under the U.S. Constitution, the *Wyatt* Standards, and the Americans with Disabilities Act.

Eric Boothe

37. Plaintiff Eric Boothe, age 22, was admitted to the Partlow Developmental Center on March 19, 1989. He had diagnoses of, among other things, moderate mental retardation, mental illness, and cortical blindness. He has many strengths, including an interest in others, verbal skills, self-care skills, and the ability to organize his leisure time. He sues by his next friend and mother, Glenda Boothe.

38. Mr. Boothe is being denied minimally adequate habilitation and care.

39. Mr. Boothe's family placed him at Partlow because they believed that an institution would provide Mr. Boothe with needed supervision. However, defendants have failed to provide Mr. Boothe with a safe and humane environment. While at Partlow, Mr. Boothe has swallowed numerous nuts, bolts, pencils, keys, buttons and other objects, and he has twice undergone surgery to remove inedible objects from his intestines, including eight checkers and a spoon. Mr. Boothe has also been physically abused.

40. Mr. Boothe's mother, who is also his legal guardian, is not promptly informed when Eric experiences problems. Also, Partlow staff have been evasive in responding to Mrs. Boothe's inquiries regarding her son's care.

41. Defendants have denied Mr. Boothe his right to habilitation in the least restrictive environment for him, an integrated community program. Since at least November 1993, Mr. Boothe's social worker has recommended that he be considered for community placement. Mr. Boothe's mother is interested in having Mr. Boothe live at home or in some other community-based setting if adequate financial support, medication and other assistance are made available.

Respectfully submitted,

/s/ Ira A. Burnim
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ATTORNEYS FOR THE PLAINTIFFS

CERTIFICATE OF SERVICE

I certify that a copy of the foregoing was served upon the attorneys for the defendants, the plaintiff-intervenors, and the United States this 10th day of March 1995, by U.S. first-class mail addressed to counsel listed below, with the following exception: Mr. Crosslin was not served by regular mail but by fax or overnight mail at the fax number or address indicated below.

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/s/ Illegible
Attorney for Plaintiffs

cc: Fern Singer (by fax)
James Tucker (by fax)

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

RICKY WYATT, by and through his Aunt and Legal Guardian, Mrs. W. C. Rawlins, Jr.,; GLENDA BRANDNER, by and through her husband and legal guardian, Wolfgang Brandner; DAVIS S. SCHOEL, by and through his father and legal guardian, J. Fred Schoel, Jr.; D.A.R. PEYMAN, JR., JOSEPH L. MOUDRY, BRENDA N. STACEY, WILLIAM HOLDEN, JR., AMELIA B. HEATH, for themselves and all others similarly situated,

Plaintiffs,

DIANE MARTIN, MARY BETH PARKER, WILLIAM SMITH, ADELIA KEEBLER, MICHAEL GUINS, RICHARD MILLS, KIM SMELLEY, FRANKIE HOPKINS, KENNETH COOK, WAYNE WILLIAMS,

Plaintiff-Intervenors

vs.

RICHARD E. HANAN, as Commissioner of Mental Health and the State of Alabama Mental Health Officer; HENRY STEAGALL, individually and in his capacity as Director of

CASE NO.
70-CV-3195

Montgomery,
Alabama

Finance for the State of Alabama; TOM BRASSELL, individually and in his capacity as Comptroller of the State of Alabama; ANNIE LAURIE GUNTER, individually and in her capacity as Treasurer of the State of Alabama; KEN WALLIS, as Receiver of the mental illness and mental retardation operation,

Defendants.

MOTION FOR LEAVE TO INTERVENE

Pursuant to Federal Rules of Civil Procedure 17(c) and 24, William Edward Haas, as next friend and legal guardian of Bridget Haas, a mentally incompetent woman, moves this Court for leave to intervene in this matter. In support of his motion, Mr. Haas states:

1. Ms. Haas is the child of Mr. Haas and his wife, Laura Haas.

2. Bridget Haas is profoundly retarded and is mentally incompetent. *Affidavit of William Edward Haas,* attached.

3. Mr. Haas is the legal guardian of Ms. Haas. *Id.*

4. Ms. Haas resides at the William D. Partlow Developmental Center in Tuscaloosa, Alabama.

5. In the matter before this Court, certain organizations and entities have asked this Court to decide whether the care at Partlow and other facilities is legally adequate.

6. If this Court decides that the care at Partlow is legally inadequate, then this Court will very likely enter orders altering and otherwise affecting that care.

7. Thus, this Court will pass on questions greatly affecting the legal rights and well-being of Ms. Haas.

8. Ms. Haas claims an interest in having legally adequate care at Partlow.

9. Ms. Haas is so situated that the disposition of this action may as a practical matter impair or impede her ability to protect her interest.

10. No parties to this litigation are adequate to protect the interests of Ms. Haas. In particular, no parties to this litigation are profoundly mentally retarded.

11. Therefore, Ms. Haas is legally entitled to intervene as a matter of right.

12. Ms. Haas's claim in this action involves questions of fact and law in common with other questions already presented to this Court in this litigation: *i.e.*, whether the care at Partlow is legally adequate and, if not, what is required to make such care legally adequate.

13. The intervention of Ms. Haas will not unduly delay or prejudice the adjudication of the rights of the original parties to this litigation.

14. Therefore, Ms. Haas respectfully requests this Court to exercise its discretion to allow Ms. Haas to intervene in this litigation.

15. This motion accompanies a pleading setting forth the claim for which intervention is sought.

WHEREFORE, Mr. Haas, on behalf of Ms. Haas, requests this Court to enter an order allowing intervention as a matter of right or, in the alternative, permitting intervene as a discretionary matter.

Respectfully submitted,

/s/ Floyd D. Gaines
J. Franklin Ozment
Floyd D. Gaines
Attorney for
Complainant-Intervenor

OF COUNSEL:

LANGE, SIMPSON, ROBINSON & SOMERVILLE
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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing document has been served upon the following:

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Ira A. Burnim
Mental Health Law Project
1101 15th Street, N.W., #1212
Washington, D.C. 20005

by placing said copy in the United States mail, postage prepaid and properly addressed, on this the 20th day of September, 1994.

/s/ Floyd D. Gaines
OF COUNSEL

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

RICKY WYATT, by and through his aunt and legal guardian, MRS. W. C. RAWLINS, JR., et al., Plaintiffs,	)	
DIANE MARTIN, et al., Plaintiff-Intervenors,	)	CASE NO.: 70-CV-3195
vs.	)	
RICHARD E. HANAN, as Commissioner of Mental Health and Mental Retardation, and the State of Alabama Mental Health Officer, et al., Defendants.	)	

AFFIDAVIT OF WILLIAM EDWARD HAAS

The undersigned William Edward Haas, having identified himself to me, the undersigned notary public, states the following on his oath:

My name is William Edward Haas. I am over 21 years of age and I have personal knowledge of the matters stated in this affidavit.

My Background

I was born on March 25, 1931. In 1955, I was graduated from the United States Military Academy, West Point, New York. In 1964 I received a Masters degree from the University of Pennsylvania. During my career as an Army officer, I served as an Associate Professor of English at West Point and as a combat officer in VietNam. I retired from military service in 1975. I am the most highly decorated surviving member of my West Point class. During my military career, I was awarded two Silver Stars, two Legions of Merit, two Bronze Stars for Valor, one Bronze Star for Service, five Air Combat Medals, and one Purple Heart. Today, I am president and owner of Office Network, a business headquartered in Hoover, Alabama.

My family

My wife, Laura, and I have been married since 1955. We have three daughters, Jane, Catherine, and Bridget.

During her pregnancy with Bridget, Laura suffered rubella. Bridget suffers from congenital spastic diplegia, a condition which cannot be treated or cured. Bridget is

profoundly mentally retarded. I am Bridget's legal guardian, and a copy of the court order establishing my guardianship is attached to this affidavit as Exhibit A.

Although she is now 30 years old, Bridget has the mental ability of a child aged 18 months, according to tests administered by mental health professionals.

The Life of My Daughter, Bridget

When Bridget was an infant, Laura and I suspected that Bridget had medical problems. We already had two daughters, and we could tell that Bridget was not developing normally.

When Bridget was 11 months old, she was diagnosed as suffering from congenital spastic diplegia. Soon after her diagnosis, our family moved to West Point, where I became an instructor at the Military Academy. Three days each week, Laura drove 50 miles to Goshen, New York, where Bridget received therapy at a cerebral palsy clinic. We began supplementing that therapy at home.

When Bridget was four years old, I was transferred to Vietnam. My wife moved to Florida, New York, located very near Goshen. Bridget continued her therapy at the cerebral palsy clinic.

When Bridget was about six years old, I was transferred to Norfolk, Virginia. Bridget began attending classes for mentally retarded children. Bridget attended classes for four hours a day, five days a week. After she had been in these classes for six months, I was transferred to Frankfurt, Germany.

The Army had a program for mentally retarded children in Frankfurt. However, this program would not admit Bridget, because the physicians there believed that Bridget could not be helped in any way.

We nonetheless managed to get Bridget admitted to a physical therapy program in Frankfurt. We also continued working with her at home. I was subsequently transferred to Ascheffenburg. After my transfer, Laura took Bridget to therapy in Frankfurt, about 45 minutes away from Ascheffenburg, on three days each week.

On my return to the United States, we lived in Hampton, Virginia. Bridget went to special classes every day during the school year.

Up to this time, Bridget had not learned to eat solid food. With the advice of a physician, we attempted to teach her to eat solid food at home, but we were not successful. Eventually we got Bridget admitted to a facility in Portsmouth. After six weeks there, she learned to eat solid food. She then began weekly visits home. Bridget remained at the Portsmouth facility for one year.

By this time, Bridget was ten years old, and she was too large for us to supervise at home. Working with the Virginia Training Center, we attempted for one year to learn skills and to teach Bridget skills that would enable her to live at home, but neither we nor Bridget succeeded. Bridget returned to the Portsmouth facility.

In 1977, our family returned to Illinois, where my wife and I were reared. Once again, we tried to allow Bridget to live at home. Every day during the school year,

Bridget went to the public school system, where she received training and physical therapy.

Bridget required 24 hour observation. By this time, she was ambulatory and, like any 18 month old child, she could not distinguish between harmless and harmful things. Unless carefully watched, she would engage in self-abusive behavior. For example, she would beat her head against the wall.

After we had been in Illinois for one year, Laura was diagnosed as suffering from exhaustion. We visited several community placements suggested by the state. None of them could provide the range of therapy that Bridget required. At best, they would have served a custodial function. In 1978, Bridget was admitted to the Warren G. Murray Developmental Center in Centralia, Illinois. The Murray Center was similar to the William D. Partlow Developmental Center in many ways. For example, there were several hundred profoundly retarded residents at the Murray Center.

When Bridget arrived at the Murray Center, she could not dress herself. She was not toilet trained. She could not communicate.

While Bridget was at the Murray Center, she learned to dress herself in part. She became partially toilet trained. She learned signs to communicate her basic needs. Her self-abuse decreased dramatically.

I became President of the Parents' Association at Murray. In that capacity, I became well-acquainted with Murray's director, Galen Goode. When I began considering the possibility of moving to the Southeast in the late

1980's, I asked him to recommend some facilities in the Southeast that could help Bridget as much as Murray had helped her.

Mr. Goode said that Georgia Mental Retardation Center in Atlanta and Partlow were the best facilities in the Southeast. I visited both facilities. While the Georgia Mental Retardation Center is very likely a fine facility, Partlow compared favorably with that facility as well as Murray.

The personnel at Partlow obviously cared for the residents. For example, Partlow did not use impersonal terms like "client" to refer to the residents. Instead, the personnel called the residents by their names. The Partlow personnel greeted and just generally conversed with the residents, even if the residents could not understand the substance of the greetings or conversations. Moreover, Partlow had an extensive staff to care for and to train the residents.

Based on my favorable impression of Partlow, my family chose to move to Alabama instead of Georgia. Bridget was admitted to Partlow in 1990.

Since Bridget has been at Partlow, she has made considerable progress. She has sharpened her skills at dressing herself. She can now put on all her clothes except her brassiere, with which the Partlow staff assists her. At Partlow, she has learned to put on her shoes, although she is still learning how to tie her laces. She can brush her teeth now, although she is still improving that skill.

While at Partlow, Bridget has become considerably less withdrawn and more communicative. When I talk to her, she looks at me. She never did this before. I attribute this improvement to the interaction that Bridget has with the staff at Partlow.

Bridget comes home every other Sunday. Laura and I love our daughter, and we wish that she could live with us every day. However, we are not young now, and we have lived many years since we began doing every thing we could to help Bridget. Despite our wishes, our experience has taught us that it is impossible for Bridget to live at home. We know that it is unlikely that Bridget could continue to improve outside a setting such as Partlow, where trained professionals give her intensive attention all day, every day. Community settings do not offer the range of services Bridget requires. Further, by design such facilities are geared to care for moderate (not profound) retarded clients. Bridget needs a congregate setting such as Partlow.

BRIDGET'S INTEREST IN THIS LITIGATION

Bridget's interest in this litigation lies in making sure that nothing happens to degrade the quality of care that she receives. As her history demonstrates, Bridget now needs and will always need the finest care. As is apparent in my history of caring for Bridget, I will do everything I can to protect her interests, including her interest in receiving the finest care. No one currently involved in

this matter is adequate to protect her interests in this litigation.

/s/ William Edward Haas
William Edward Haas

STATE OF ALABAMA)
JEFFERSON COUNTY)

Sworn to and subscribed before me this the 20 day of September, 1994.

/s/ Carolyn Key Reaves
Notary Public

Commission Expires: Illegible

EXHIBIT A

LETTERS OF GUARDIANSHIP

STATE OF ALABAMA PROBATE COURT

COUNTY OF TUSCALOOSA CASE NO. 92-999

BE IT REMEMBERED, AND MADE KNOWN TO ALL WHOM IT MAY CONCERN;

That on the application of William E. Haas to my said Court for Guardianship by Court appointment, I have caused these LETTERS OF GUARDIANSHIP to issue to William E. Haas, Guardian of Bridget A. Haas, the incapacitated person, and in every case in which the occasion may require, the said Guardian is authorized and directed to exercise the following powers and duties:

All powers and duties conferred under *Code of Alabama*, 1975, No. 26-2A-108, as the lawful Guardian of the said ward.

Witness my hand and official seal this 21st day of July, 1992.

/s/ W. Hardy McCollum
Judge of Probate

STATE OF ALABAMA
COUNTY OF TUSCALOOSA

I, W. Hardy McCollum, Judge of Probate, hereby certify that the foregoing is a true and correct copy of LETTERS OF GUARDIANSHIP issued to William E. Haas as Guardian of Bridget A. Haas, as same appears of record in my office.

Witness my hand and official seal this 21st day of July, 1992.

/s/ W. Hardy McCollum
Judge of Probate

IN THE UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF ALABAMA
NORTHERN DIVISION

RICKY WYATT, by and through his Aunt and Legal Guardian, Mrs. W. C. Rawlins, Jr.,; GLENDA BRANDNER, by and through her husband and legal guardian, Wolfgang Brandner; DAVIS S. SCHOEL, by and through his father and legal guardian, J. Fred Schoel, Jr.; D.A.R. PEYMAN, JR., JOSEPH L. MOUDRY, BRENDA N. STACEY, WILLIAM HOLDEN, JR., AMELIA B. HEATH, for themselves and all others similarly situated,

Plaintiffs,

DIANE MARTIN, MARY BETH PARKER, WILLIAM SMITH, ADELIA KEEBLER, MICHAEL GUINS, RICHARD MILLS, KIM SMELLEY, FRANKIE HOPKINS, KENNETH COOK, WAYNE WILLIAMS,

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vs.

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Finance for the State of Alabama; TOM BRASSELL, individually and in his capacity as Comptroller of the State of Alabama; ANNIE LAURIE GUNTER, individually and in her capacity as Treasurer of the State of Alabama; KEN WALLIS, as Receiver of the mental illness and mental retardation operation,

Defendants.

COMPLAINT IN INTERVENTION

I. Jurisdiction And Venue

1. In this complaint, William Edward Haas, as next friend and guardian of Bridget Haas, a mentally incompetent woman, requests this Court to declare that the care at the William D. Partlow Developmental Center is legally adequate and to enjoin the defendants in this action from ceasing or otherwise degrading that care.

2. This Court has already assumed jurisdiction over the question of whether the care at Partlow is legally adequate.

3. This Court has jurisdiction over this complaint pursuant to 28 U.S.C. §§ 1331 and 1367, as well as 42 U.S.C. § 1983.

4. Pursuant to 28 U.S.C. § 1391(b)(2), the proper venue for this action lies in the Middle District of Alabama.

II. Facts

5. Bridget Haas is the daughter of William Edward and Laura Haas.

6. Bridget Haas was born with congenital spastic diplegia.

7. Ms. Haas is profoundly mentally retarded. Although she is now 30 years of age, she has the mental development of a child aged 18 months.

8. Ms. Haas is mentally incompetent.

9. Mr. Haas is the father, next friend, and lawfully appointed legal guardian of Ms. Haas.

10. Ms. Haas currently resides at the William D. Partlow Developmental Center in Tuscaloosa, Alabama, where she has lived since 1990.

11. The care provided at Partlow has improved Ms. Haas's skills in every day tasks, such as dressing, brushing her teeth, communicating basic needs through sign language, grooming herself, and using the toilet.

12. Ms. Haas needs care of the quality and type provided at Partlow.

13. In particular, Ms. Haas needs the care of competent professionals, which Partlow provides, in a congregate setting.

14. The Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment to the United States Constitution protect the right of Ms. Haas to continue to receive, at Partlow, care of the type currently provided by Partlow.

15. Article I, § 6 of the Constitution of Alabama (1901) protects the right of Ms. Haas to continue to receive, at Partlow, the type of care currently provided by Partlow.

16. In this litigation, certain organizations and entities styled as parties-plaintiffs have urged this Court to decrease the services offered at Partlow or to close Partlow.

WHEREFORE, pursuant to 42 U.S.C. § 1983, Mr. Haas, as legal guardian and next friend of Bridget Haas, respectfully requests this Court to order the Department of Mental Health and Mental Retardation and Richard Hannan, in his official capacity as Mental Health Commissioner for the State of Alabama, to continue to provide Bridget Haas with the current standard of care, subject to reasonable improvements as indicated by medical science, provided by the William D. Partlow Developmental Center and to do so at the William D. Partlow Developmental Center in Tuscaloosa, Alabama. Ms. Haas further requests this Court to award her attorneys' fees and expenses, plus the costs of this action.

Respectfully submitted,

/s/ Floyd D. Gaines
J. Franklin Ozment
Floyd D. Gaines
Attorney for
Complainant-Intervenor

OF COUNSEL:

LANGE, SIMPSON, ROBINSON & SOMERVILLE
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CERTIFICATE OF SERVICE

I hereby certify that a copy of the above and foregoing document has been served upon the following:

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/s/ Floyd D. Gaines
OF COUNSEL